PUBLIC HEALTH NURSING

Official Organ of the National Organization for Public Health Nursing, Inc.

SELECTION OF PATIENTS FOR NURSING SERVICE

THE PROBLEM of selection of patients for nursing visits is not a new one. At no time in the history of public health nursing has the supply of nursing service been adequate to meet all the needs, unless perhaps in very limited demonstration areas. Some services, some families, have always had to be neglected. If we are honest we must admit that rarely has this selection been made consistently on the basis of a careful study of the needs.

Today, with the necessity for economy curtailments in private agencies, attention is again focused on this problem. Every agency wanting to give the best possible service to the community must study its entire program carefully in relation to community needs. In addition, it must analyze each individual case to decide: How should visits be spaced? Which visits should be made? How much can the family do, and how much help does it need from the nurse?

Nor is the private agency the only one which faces this necessity. True, the official agency often has more funds in relation to what it is expected to do. But nowhere has it sufficient nursing service to meet all the needs adequately. And moreover it has the same educational aim as the private agency—to develop family responsibility for using available resources to care for its own health.

Agencies in the vanguard of progress have long ago faced this problem. They have planned ahead regarding the amount and kind of service they should give and the place where such service would do the most good. They have planned jointly with other nursing agencies to avoid overlapping and to meet all the needs. In some cases they have combined with other agencies for more effective community service. They have selected families for intensive, long-time health supervision on the basis not only of their need but of their acceptance; their ability and willingness to use the help of the nurse in meeting their own problems.

In this issue a specialist in maternity nursing discusses the distribution of visits in a maternity service. (Page 197.) Her comprehensive analysis of the problem indicates the need for shifts in emphases; for a much more careful planning than is now the practice.

The bases for selection of patients or families for nursing visits will depend on the individual situation. However, certain criteria are applicable to all: the pressure of immediate need because of the patient's condition; the total opportunities that the family has at a given time for health service and instruction; the ability of the family to care for its own health.

Who shall make the selection? It is of course primarily a professional problem requiring expert analysis of the needs. With this information in hand, the responsibility for the selection of services to be rendered and individual cases to be served may well be shared with the board of directors—as is being done in at least one agency—or the advisory committee, and with the medical advisory committee.

We believe that the future will see a much greater emphasis on careful planning of nursing visits on the basis of the greatest need both from the standpoint of the individual patient or family and the community picture as a whole.

The Voluntary Agency in a Democracy

By MICHAEL M. DAVIS, Ph.D.

The functions of a voluntary health agency in these changing times are discussed at the annual meeting of the National Organization for Public Health Nursing

THE HEALTH of the people is a public concern. Agreement with this principle is wholly compatible with the continued existence of voluntary as well as governmental health agencies. Education is recognized even more fully than health as a public responsibility, but the American system of public schools and state universities is accompanied by vigorous private institutions and by educational experiments whose notable contributions to the policies and methods of education are nowhere better recognized than among public authorities themselves. Conceived in a truly democratic spirit, our local, state, and national governments belong to us. They are not enterprises extraneous to the citizen. From this point of view governments are organizations through which certain needed services can be performed better at a given time than by individuals themselves or by those less comprehensive organizations which we know as voluntary agencies. Governmental action and voluntary action are not opponents but partners.

After-dinner oratory concerning voluntary agencies has commonly extolled their functions as initiators of new policies and methods through research and demonstration; as critics of government when government is naughty; as supporters of better personnel and larger appropriations when government is good; as the means of furnishing services of certain kinds or to certain social groups which would not at the time be supplied by government, and of giving up those services as soon as possible.

It would be easy to supply comforting illustrations of these functions. It is mainly through the efforts of the American Medical Association, the national voluntary professional association of physicians, that medical education in the United States has been transformed during the last thirty years and lifted from a largely commercial level to an almost wholly scientific plane. Through long years the American Social Hygiene Association has carried forward the studies and the persistent public and professional education on which rests much of the now widespread governmental program for control of syphilis and gonorrhea. For over twenty-five years the National Organization for Public Health Nursing has played a notable part in establishing educational standards, advancing the organization, and improving the professional practices of the nurses in its field. But I know that you wish me to do more than to spread butter on slices of bread that are already cut.

Many of you are worried about the future of voluntary health agencies. Are growing governmental activities rendering their services unnecessary? Are these and related influences drying up their sources of financial support?

I do not ignore the existence of these problems nor minimize the present anxieties. I am, however, prepared to answer these questions in the negative. I believe that voluntary health agencies will continue to have functions to per-

form and will continue to find support for the performance of these functions in nursing and in other fields of medical work. But this favorable answer is qualified by certain conditions. Voluntary health agencies will continue to have functions to perform and to find support for the performance of these functions, provided they keep always alive to the new demands of changing times, basing their policies and their appeals on future needs rather than on past performances. Put in another way, the life of the voluntary health agency will depend more than anything else upon two qualities—imagination and courage: imagination to conceive, investigate, and define what unmet needs are; courage to scrap past activities and work on that sometimes uncertain and often controversial borderline which runs between the present and the future.

PROTECTIVE ATTITUDE UNDESIRABLE

The dangers of voluntary agencies have been especially exemplified during the depression. Since 1930 many of the conversations among directors and officials of voluntary agencies seem to have centered around the question: What shall we do to be saved? This interrogation implies a protective, defensive attitude rather than imagination and courage. During the depression period notable illustrations of initiative, imagination, and courage in the health field have been manifested by government agencies. We can all have pride in our American democracy that this has been so. A protective attitude on the part of the voluntary agencies is not wholesome.

Dare I give illustrations? Recently I visited a city of some 150,000 population in which I was told were four nursing agencies, most of which maintained specialized services, so that it was declared possible for a single family to be visited during a week by eight different kinds of nurses. A small group of physicians and laymen, wise in the ways of the world, united in the fond hope that this proliferation of nursing could be abolished but assured me of their sad belief that it might take twenty years to do it. When I inquired timidly the chief obstacles to this consummation, I learned that most of the obstructions had names—and, I am compelled to state, feminine names. Mrs. Brown, for instance, was said to be chairman of a committee of one of the agencies to deal with tuberculosis nursing. Mrs. Brown had been chairman of that committee for a number of years. Mrs. Brown's husband was a local financial magnate. The connections and consequences of these facts do not require explanation to this audience.

I admit, as you do, that cultivating the sentiments of contributors is a form of fireside nursing which may be difficult to combine with a flexible, imaginative, and courageous policy of community nursing service; that the political dangers of governmental agencies can be matched by the protective and insular attitudes of private bodies; that the personal interests of executives influence both public agencies and private, because both are run by human beings; that specialized interests of voluntary agencies and categorical approaches to health problems may be as destructive to the organization of community health programs as the political friendships of a county supervisor may be to their efficiency after they are organized. The kind of programs on which voluntary health agencies will be most useful in the future will require intelligent rather than sentimental giving from individuals and flexible as well as generous policies on the part of community chests and foundations. Cultivation of these types of support will require some changes in the kinds of appeal as well as in the character of the programs to which many voluntary health agencies have been accustomed in the past. Budgets may become smaller, but I dare say that this

may not always be so disadvantageous.

To return more specifically to public health nursing, emphasis might be laid on several important functions to which voluntary agencies in this field should direct their attention. I will mention only two: (1) the enlargement of public health nursing service, and this particularly in two directions—to paying patients and to rural areas (2) the organization of community nursing service, including the services rendered by private duty nurses and by salaried nurses working under hospitals, health, or welfare departments or visiting nurse associations.

SERVICE TO PAYING PATIENTS

I am convinced that there lies immediately ahead of the local voluntary nursing associations, with the backing of their national body, the opportunity to enlarge nursing service to paying patients, and this possibility seems to me the chief guarantee of the future maintenance of local nongovernmental nursing agencies. Paying patients of moderate means often need nursing service which they do not now receive and which they can secure only through nursing organizations. They cannot pay for it on the private-duty basis. Visiting nurse service to these patients may be paid for directly by the visit or by the hour, or it may be provided through extension of the voluntary hospital insurance principle. Here is one of the opportunities just ahead.

Work locally with the voluntary hospital insurance plan; encourage the expansion of their services in your direction. Get the N.O.P.H.N. to engineer coöperative studies and suggestions with the committee of the American Hospital Association which is steering and standardizing nonprofit hospital insurance plans throughout this country. Cultivate among the supporters of local visiting nurse associations and among their boards of directors the same attitude which the voluntary hospitals have so successfully developed among their contributors and in the mind of the general public; namely, pride in deriving a large proportion of income from paying patients, while still requiring considerable charitable gifts to meet the needs of those who cannot pay. Get rid of the incubus of the "charity attitude" as the only basis for support of visiting nursing associations. It may take time to do this, and there may be communities wherein some board members will have to retire first. The hospitals required a generation to accomplish the transformation, but they are mostly managed by men. Women can do it in ten years or less.

COMMUNITY NURSING SERVICE

The question arises whether local or national nursing organizations are suited to the task of the community organization of nursing service. Community nursing councils and similar agencies, made up primarily of nurse representatives, are well adapted for studying local needs and making technical plans, but they are not suitable bodies for getting action on plans. They are especially unsuitable when changed relations among the general health and welfare agencies are required, as is often the case. For bringing about action, lay groups of effective citizens must be enlisted as well as the professions, and these citizens must carry the main burden of transforming technical plans into working realities. Among other difficulties, the professional groups find it hard to overcome their ingrained specializations. We cannot have community organization of health services if, in a city of 100,000 population or more, we depend upon a series of specialized committees or councils relating respectively to nursing, hospitals, home medical care, tuberculosis, maternity and child welfare, and syphilis. Such a series of groups will improve technical performance, but will

not bring a unified approach and administrative coördination under either private or public auspices. Yet coördinations and unifications are necessary if we are to succeed in making medical or nursing service most effective, most economical, and most widely available. Nursing agencies have a share in the community organization of nursing service, but a large part of that task must be performed by others. Learn therefore to recognize the point where the special functions of professional agencies should stop and the broader functions of community action groups must begin.

THE PROBLEM OF CHANGE

The problem of the hour is the problem of change. How much change, and in what directions? This is what worries us. This is what inspires us. At this point may I read a few paragraphs from an address by one of the wisest of living men, Alfred North Whitehead:

> If you keep to the northern temperate zone, in every country that you can pass through . . . you will find some profound agitation, examining and remodeling the ways of social life handed down from the preceding four hundred years. This agitation as a major feature in social life is the product of the past twenty-five years. Of course this unrest has its long antecedents, but within this final short period the disturbance has become dominant. Undoubtedly, something has come to an end.
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> It is also worth noticing that the center of disturbance seems to lie within each country. We are not dealing with the repercussion of a revolution with one local center . . .
>
> When in this survey we cross the Atlantic and come to America, I do not think that there is exaggeration in the refrain, that something has come to an end. We stand at the commencement of a new thrust in sociological functioning . . . Do not misunderstand me. In each nation we all want to continue to aim at our old ideals. We can only preserve the essence of the past by the embodiment of it in novelty of detail.*

I have often pondered Professor Whitehead's phrase, "a new thrust in sociological functioning." Will that thrust push us up or down—up into sunlit air and broad vistas, or down beyond our depth into murky waters? It is not within our powers as individuals to answer this question, but the answer is within our control as citizens—as participants in the organized activities which move a community and the nation forward.

When the glaciers came down from the north over Europe and America, some tens of thousands of years ago, living things had to adjust themselves to a cold climate and other alterations. The animals that were able to utilize the opportunities as well as to withstand the disadvantages of the new conditions were the ones that survived. Man survived. He was thus adaptable. The dinosaurs perished. They were not. None of us can safely predict just what the future holds, but most of us agree that we are in a time when new things are coming. To survive, and to be useful as well as ornamental survivors, we must be able to utilize as well as to withstand change. To this end perhaps the most important qualifications are brains above the neck and intestinal fortitude below it.

As I utter these evolutionary analogies, I am reminded of a limerick which may be an appropriate conclusion. A gentleman took his little boy to the zoo one Sunday afternoon. Visiting the monkey house at the desire of young James, they paused before the cage of a large ape who was crouched on the truncated branch of a dead tree, such as is placed in these cages by kind keepers of zoos. For the edification of his son, our friend recited the following:

> This, my son, is a chimpanzee,
> Seated upon the ancestral tree
> From which we sprang.
> I'm glad we sprang, for if we'd sat,
> Jimmy, my boy, you'd look like that!

It takes courage to spring from a familiar place to a strange one. It re-

*Cabot, Philip. "Contemporary Conditions: A Challenge for Business Men." *Harvard Business School Alumni Bulletin*, July 1937.

quires imagination to make that courage useful when one has landed after the spring. The future of voluntary agencies in our democracy might be said to depend on the extent to which we select, admire, and emulate those of our ancestors who had the imagination and the courage to utilize as well as to withstand change.

Presented in part at the dinner of the Board of Directors, Advisory Council, and Council of Branches of the National Organization for Public Health Nursing, New York, N. Y., January 25, 1939.

COMMITTEE ON THE USE OF LAY COMMITTEES

THE INCREASED INTEREST of the citizen in public health programs is focusing attention on the need for using this citizen-interest in a constructive manner. For many years public health nurses in rural areas have used lay committees to assist them in a multitude of ways. Also, the National Organization for Public Health Nursing has for the past ten years carried on an educational program for board and committee members throughout the United States who are interested in this field of public health nursing. Recently many state and local health departments have organized committees to assist them in their program. As an illustration, the article by Mary Arnold on "New York's District Health Committees" (page 206) describes the effective use of citizen participation.

Because of this development, it seemed wise to have a committee working with the National Organization for Public Health Nursing to study the best ways of organizing and using lay committees. Dr. Wilson George Smillie, Professor of Public Health and Preventive Medicine, Cornell University Medical College, New York City, has agreed to take the chairmanship of this informal committee. Other members serving on it at the present time are:

Carl E. Buck, Dr.P.H., Field Director, American Public Health Association, 50 West 50 Street, New York, New York.

Martha M. Eliot, M.D., Assistant Chief, Children's Bureau, U. S. Department of Labor, Washington, D. C.

V. L. Ellicott, M.D., County Health Officer, Montgomery County Health Department, Rockville, Maryland.

Donald G. Evans, M.D., Director of Health, State Department of Health, Seattle, Washington.

Amelia Grant, Director, Bureau of Nursing, Department of Health, New York, New York.

Ira V. Hiscock, Professor of Public Health, The School of Medicine, Yale University, New Haven, Connecticut.

W. Myers Smith, M.D., Director, Division of Maternal and Child Health, Arkansas State Board of Health, Little Rock, Arkansas.

Mrs. Arch Trawick, Director of Health Education, Davidson County Department of Health, Nashville, Tennessee.

Felix J. Underwood, M.D., Executive Officer, Mississippi State Board of Health, Jackson, Mississippi.

Clifford E. Waller, M.D., Assistant Surgeon General, U. S. Public Health Service, Washington, D. C.

Mrs. Frederick S. Dellenbaugh, Jr., Boston, Massachusetts, *ex officio*.

Nursing Visits to Obstetric Patients

By HAZEL CORBIN, R.N.

How should public health nursing visits to obstetric patients be distributed? When does the obstetric patient need such visits? How many and what kind does she need?

IT IS NOW well known that every obstetric patient needs medical and nursing supervision, care, and instruction throughout pregnancy, labor, delivery, and the puerperium. No amount of perfect medical and nursing care at any one period can offset the lack of either during the other periods. Good antepartum care which is not followed by good care at and after delivery protects mothers and babies from illness, death, and injury due to the abnormalities that develop during pregnancy only to leave them the prey of those that arise at delivery and afterward.

It is only when the care is "adequate in all respects" during the ante-, intra-, and postpartum periods that it can make maternity safe. To be "adequate in all respects" the care should be continuous, as well as complete, and of the same high quality during each period of the maternity cycle. This essential continuity and uniformity can be secured when the mother's care is directed by the same competent physician or good hospital service from beginning to end.

The nursing and medical part of obstetric care are so dependent one on the other—each so definitely but one part of a unit—that neither can be planned without a consideration for the other. Indeed, the part of the care the doctor gives and the part delegated to the nurse will differ to meet the varying conditions in different communities. The nurse's work must complement the doctor's so the mother will receive care that is complete and the doctor will have the assistance he needs to enable him to do his work well. That complete care should include:

1. The health history, physical examinations, clinical and home observations, and laboratory work necessary to learn the mother's general condition, evaluate her reactions to pregnancy, and watch the baby's development week by week, and to determine the baby's presentation before labor begins.

2. The advice, medication, food, and treatments necessary to correct or relieve abnormalities or discomforts and to conserve the mother's energy.

3. The help necessary to enable the mother to follow the doctor's advice successfully and to meet satisfactorily the problems that disturb her peace of mind.

4. Instruction of the father as well as the mother in the hygiene of pregnancy, the essentials of good obstetric care, and the preparation for and care of a baby.

5. Help in making the best possible arrangements for adequate medical and nursing care and household help at and after delivery and help in developing a family plan for giving the baby the care he needs while reserving time for the other pleasures, responsibilities, and interests of life.

6. Constant nursing during labor and delivery to comfort the mother, reassure her, and protect her from fatigue, fear, injury, infection, and unnecessary suffering.

7. Wise management of labor and an aseptic skillful delivery without preventable pain, injury, depletion, or blood loss.

8. Examination, observation, and laboratory work necessary to learn and watch the condition of mother and baby after delivery.

9. The advice, medication, food, and treatments for mother and baby necessary to pre-

vent fatigue, infection, injury, and unnecessary discomfort during the puerperium.

10. Whatever help is necessary to bring the mother to that state of health which is her optimum and to give the baby the best chance for normal development—mental and emotional as well as physical.

ANTEPARTUM VISITS

The spacing of antepartum nursing visits in any community is therefore partly dependent upon the content of visits resulting from the division of work between doctor and nurse. This division is in turn dependent upon the kind and amount of medical and nursing service in relation to the kind and number of patients, the hospital beds available for obstetric patients, and the travel facilities in that community.

Some mothers have few problems, are eager to learn, or learn easily, while others are irresponsible, indifferent, overwhelmed with burdens, or slow to learn. Some can be taught to send a report by letter or telephone and a urine specimen by mail or messenger in place of some of the regular visits. Others must be seen very frequently to keep them following advice and instructions. And there is always the occasional patient who must be watched closely to prevent an impending disaster. It is obviously unwise to follow the same plan for seeing or hearing from every mother without consideration for these individual differences.

When patients are many and travel time-consuming, and *when medical and nursing services though limited in quantity are adequate in quality of visit content,* the patient's visits to the doctor may be reduced in number if the nurse's reports after her visits satisfy him that the patient is in good condition; nursing visits can safely be few and far between when the patient visits the doctor or hospital clinic every week or two and attends mothercraft classes regularly; the patient's visits to the doctor and nurse may be reduced to a minimum when she is an apt pupil with no problems to trouble her, and when she can be depended upon to follow instructions, to send routine reports and specimens regularly, and to report new symptoms at once.

It is evident that no fixed schedule for visiting can apply to all pregnant mothers in any community and that the content of the visits should be sufficiently elastic to meet the different situations in different communities.

THE INTRAPARTUM VISIT

There is no way to "schedule" nursing visits during labor. The mother's need necessitates one long visit that begins when labor is established and ends when the mother and baby are comfortably settled in their beds and someone has been instructed to care for them until the nurse's next visit.

POSTPARTUM VISITS

During the postpartum period the mother needs, in addition to the visits of the public health nurse, some responsible woman to stay with her continuously to give her and the baby the attention they need between the nurse's visits. The intelligence and dependability of that woman, be she relative, friend, neighbor, or paid worker, will influence the number and the content of the postpartum visits that must be made by the public health nurse. In many communities classes in home nursing for the women will create a supply of "neighbor-nurses" who can be depended upon to care for each other under the supervision of the public health nurse. If it is not a neighbor but someone from a distance who will stay with the mother, she can be taught individually or at mothers' classes how to give the necessary care under the nurse's supervision. When the public health nurse visits to supervise rather than to nurse, her visits can be less frequent, and after the first one or two they will consume less time than if she were giving all the nursing care.

There is no justification for spending time, effort, and money on nursing visits that could be made unnecessary by more careful teaching or wiser use of community facilities. Certainly these unnecessary visits are not justified while there are in this country more than a million prospective mothers every year who have not yet learned enough about their need for care to seek it before the completion of the sixth month of pregnancy—too late to learn how to prepare for and care for the baby properly, too late to control many of the conditions causing disaster, too late for effective antisyphilitic treatment.

It is unthinkable that we should continue to concentrate the little public health nursing service which is available on postpartum and antepartum visiting while there are in this country hundreds of thousands among the million mothers delivered in their homes every year who labor with needless mental and physical anguish because there is no nurse with them; while innumerable doctors are struggling alone to deliver women safely and failing sometimes for lack of the assistance a good nurse could have given them; while thousands of women are delivering themselves without benefit of either doctor or nurse.

MAKING THE VISIT SCHEDULE

With these conditions in mind a schedule of public health nursing visits to obstetric patients could well be based on the following assumptions:

1. So long as there are mothers delivered in their homes without other skilled nursing, it is safer for the mothers and better economy for the community to distribute throughout the whole maternity cycle the public health nursing service that is available, rather than to limit it to the care of mothers during any one period—antepartum, intrapartum, or postpartum.

2. When the nurse conducts classes for expectant mothers and fathers and when she invites mothers to come to her office at stated hours for a part of their care she can give individual care and advice before and after class and during the office hours without spending time in travel. The class instruction will reduce the time that must be spent in teaching in the individual homes and in getting the understanding help of the patients' husbands. Furthermore the combination of class instruction with individual teaching in the home is more effective than is either one without the other; for the interplay among the members of the group adds incentive to their learning, while home teaching helps each one apply that learning to his or her individual home situation.

3. Until all pregnant mothers in the community seek care early in pregnancy, a part of the public health nursing time available for obstetric nursing should be given regularly to reaching those mothers who do not seek medical care. Among all the mothers in the community their need is the greatest. Various methods may be used for finding these mothers. Satisfied ex-patients may be organized as scouts for their own neighborhoods to search out every pregnant mother not under medical care and to persuade her to go to a doctor, hospital, or mothercraft class. Intelligent volunteers may be directed to call at every home twice a year and leave a simple attractive leaflet about the essentials of obstetric care and the local facilities for that care. Similar material may be covered in talks to groups of all kinds, in broadcasts, and in newspaper articles. An invitation to mothercraft classes may be published continuously in the local newspaper. The nurse can then direct her time and attention to visiting and supervising the diffident or indifferent mothers who do not respond to these measures until they can be persuaded to put themselves under competent medical supervision.

4. These mothers and any others who for one reason or another have not en-

gaged a doctor or registered at a hospital clinic will need weekly or semiweekly visits to impress them with the importance of putting themselves under competent medical supervision, until they can be persuaded to do so. Without the guidance of the doctor's findings, advice, and instruction, the nurse will need to observe these patients closely and often, in order to detect signs and symptoms of abnormalities in time to help arrange care which will prevent disaster. Solicitous concern in relieving minor discomforts and in teaching the mother how to prepare for and care for her baby may make more effective the nurses' efforts to convince the patient of her need for medical supervision.

5. The intelligent mother under the supervision of a competent physician who sees her regularly and who will deliver her at home, if she attends mothercraft classes or receives comparable instruction individually will be safe with one or two antepartum visits to help her in adapting the instruction to her own home situation and to check with her the preparations she has made for the home delivery. She will need constant nursing during labor and delivery and then postpartum visits to give or supervise her after-care and the baby's early care and to initiate her in the care of her own baby. The normal mother cared for between the nurse's visits by a responsible person will need: (1) daily visits for the first three to five days until the baby's nursing is well established and the mother is on the high road to recovery (2) weekly visits until the mother can take the baby regularly to her doctor (3) an occasional visit until she has had the final postpartum examination.

6. If such a mother, under the supervision of the competent doctor, is to be delivered at the hospital, she will need (1) the one or two antepartum visits (2) one or two visits when she returns from the hospital to initiate her in the care of the baby (3) the weekly visits until she can take the baby regularly to her doctor (4) an occasional visit until she has had the final postpartum examination.

7. Mothers who register early in pregnancy at a Grade-A hospital having antepartum and postpartum clinics with a follow-up service for delinquent patients, and mothercraft classes conducted by qualified nurses, will have adequate care without being visited in their homes more than once or twice during pregnancy to help them adapt the instruction to their individual home situation and again after they leave the hospital to help them apply what they have learned about baby care to the actual care of their own babies.

8. The mother who comes under care late in pregnancy will need frequent visits in the time that is left to help her with the arrangements for her care at delivery and to teach her how to prepare for and care for her baby. She will need extra postpartum visits to teach her some of the things she should have learned during pregnancy.

9. The mother who learns or responds slowly, the one who cannot be depended upon to report unexpected or new symptoms or discomforts, the one with disaster impending because of some abnormality or unsolved social problem, and the one who is being cared for by an untrained midwife—each one must be visited during each period of the whole cycle as the individual need indicates regardless of any schedule.

Organizing, distributing, and spacing nursing visits to obstetric patients on the basis of these assumptions will concentrate the work where according to our present knowledge it is most needed. This will not mean less public health nursing in obstetrics, but a wiser distribution of the little that is now available until there can be more.

Safety in Home, School, and Industry

By W. WEBBER KELLY, M.D.

Safety enters into every phase of our life. It connotes not only accident prevention, but the prevention of disabling illness. It requires a far-reaching educational program

IN THE MINDS of the public, the question of safety appears to center around the problems of traffic in relation to accidental death and injury. As the result of the dramatic publicity which this type of catastrophe receives, we lose sight of the necessity for eternal vigilance in situations far removed from the scene of this holocaust created by the so-called blessings of modern civilization. Terrible as this ever-increasing source of death, suffering and economic loss may be, it constitutes but a part of the price we are called upon to pay for the culpable ignorance and carelessness which mark our daily lives.

Only a part of the picture is revealed by the disturbing fact that in 1937 some thirty-nine thousand five hundred persons were killed, over two hundred thousand permanently injured, and an economic loss of over a billion dollars sustained as a result of this modern menace. Equally disturbing is the toll from all accidental causes combined: 106,000 deaths, one every five minutes; 375,000 persons permanently disabled, one every 80 seconds; almost 10,000,000 people temporarily disabled, one every 3 seconds; and an economic loss of $3,600,000,000, $120 every second.*

However, the word *safety* has a much broader significance than its application to the problem of accidental death and injury alone. Safety enters into every phase of our existence and assumes importance in the prevention of both disease and disabling illness which constantly threaten our health and happiness. The nurse has a responsibility for safety in the home, in the school, and in industry.

*Accident Facts. National Safety Council, 50 North Wacker Drive, Chicago, 1938.

HOME SWEET HOME

While the sentiment contained in this lovely song is inspiring, a cold analysis of the physical facts is somewhat startling. Let us face the undisputed statement that almost as many lives are lost and almost as many persons accidentally disabled in the supposed safety of the home as on the streets, on the waters, and throughout all industry. It was Mark Twain who humorously remarked that he hated to go to bed because so many people died there. He could have said the same thing with more serious tragic import about the home itself.

The number of domestic accidents and disabling injuries is close to the number sustained through the use of automobiles. The types of serious accidents that occur in the home are enumerated and discussed in a pamphlet issued by the National Safety Council entitled *Hurt at Home*, a copy of which should be in every household.

And what of the hazards to health existing in the home due to inadequate or improper food, faulty sanitary conditions, insufficient ventilation, and the absence of necessary medical care? How trite is the saying, "One half of the world does not know how the other half lives"!

But most nurses do know. The question is, what can they do about it? With proper organization and planning a great deal can be done to ameliorate these unfortunate conditions. The nurse with opportunities for personal and family contacts, and fortified by the respect her calling inspires in the minds of the public, possesses unequaled opportunities for worthwhile service in this great undertaking. To this task she must bring knowledge, tact, and deep human understanding.

The bases for the terrific toll of life, suffering, and economic loss are ignorance and carelessness, which an educational program will do much to overcome. When the nurse discovers conditions in the home conducive to sickness and accident she can tactfully offer suggestions for their elimination. In most cases her advice will be gladly accepted.

The formerly limited sphere of the nurse has been enlarged by the development of new fields of nursing. Conspicuous among these fields has been the trend in the direction of public health nursing. The public is slowly but surely awakening to the importance and need of public health service. This type of service without adequate public health training of personnel is, however, ineffective, and results in economic waste. Such training in addition to the curriculum which the nurse's student years provide, particularly fits her for the fight which in her capacity as industrial, school, city, or county nurse, she must wage against the continuing increase in the incidence of accident and disease. The success of this work is predicated upon proper organization, and in order to be effective the program must be guided and supervised by those properly equipped for the task.

THE LITTLE RED SCHOOL HOUSE

The full purpose of the safety movement in its relation to the public and parochial school systems is far from realized. In some school systems the type of health service rendered is both inadequate and ineffective. In many localities there is a complete absence of coöperation between school and health authorities. Without such mutual counsel no worth-while safety plan can be inaugurated. Such a plan should include instruction of the pupils on accident prevention and first-aid measures as well as health problems. This work should be outlined by the health department in collaboration with the superintendent of schools, and teachers should render every assistance to the school nurse in making the plan successful.

Meetings of groups of teachers and nurses with pupil demonstrations should be held at regular intervals. The instruction of teacher groups by the nurses in the obvious symptoms of sickness with a view to preventing the spread of communicable disease should be systematically carried out. The help of the teachers in the early detection of the premonitory symptoms of communicable diseases would become increasingly valuable if more thorough instruction and demonstration were given on this subject by the nurse. The teacher's responsibility in sickness and accident prevention cannot be overemphasized. She has a very definite part to play in the solution of this serious problem.

Thorough periodical physical examinations of each child with follow-up work are absolutely essential for adequate health supervision. Frequent contacts with parent-teacher associations by the nurses and school physician, with talks upon the prevention of accidents and sickness, are imperative if our objectives are to be attained. These objectives are:

1. To develop in the child a sense of personal responsibility for his well being.
2. To develop in the pupil a sense of community responsibility for the prevention and control of diseases and accidents.

3. To teach every student in the upper grades measures in minor injuries, stressing the necessity of calling for expert advice and treatment as soon as possible in serious emergencies.

4. To help the child develop intelligent control of conduct, motivated from within.

5. To develop a closer relationship between the school and the home throughout the child's entire school life.

Our problem is therefore essentially an educational one and we must instruct the parent, the child, and the teacher in order to bring about an appreciation of good health and living.

THE NURSE IN INDUSTRY

The necessity for public health training is becoming more and more recognized as an essential to nursing in industry. The nurse in industry functions in four capacities: (1) as a technician (2) as an executive (3) as a social worker (4) as a teacher.

Her first-aid procedures, her assistance to the physician, and her surgical technique should be above reproach, for these constitute the foundation stones of her service.

The requirements indicating her ability to function as an executive are obvious. They include the systematic, orderly conduct of her department; its discipline, atmosphere, and readiness for prompt service, as well as the keeping of accurate records.

As a social worker, she must be able to recognize the problems that arise so often among workers and their effect upon the individual. These social factors frequently delay recovery from accidents and sickness. The nurse's service does not cease at the plant, for she is often called upon to visit the homes of those absent from work as the result of disabilities. Here many problems of a social character will challenge the effectiveness of her work as a whole, and her help to the family in solving them will increase her value to the industry in which she is employed.

As a teacher she must impress upon all those immediately under her care, as well as their families, the importance of proper health measures and living conditions. She should urge upon them the necessity of reporting early symptoms of illness.

Much could be said on the subject of the role of sickness in the accident problems of industry. Any worker who is even mildly sick loses his efficiency and is often the victim of injuries which might have been avoided had he been in robust health. Many workers in industry continue to labor with sore throats, elevated temperatures, persistent coughs, and headaches which may very well be the precursors of some acute or chronic malady. Worry over economic conditions in the home is another factor that must be reckoned with in accident prevention. The use of alcohol has been sufficiently emphasized as a contributing cause. The nurse must use her best efforts to detect the after effects of alcohol in those patients coming under her observation.

It must not be forgotten that industry is an integral part of community life and cannot be unaffected by what happens to its employees during two thirds of their daily lives. In her contacts with the worker, the nurse should at all times regard him as an individual and not alone as the victim of some particular accident. In the treatment of even minor injuries, she should observe him closely for the detection of possible ailments of which he may not complain.

The nurse must assume some responsibility for sanitation in the plant and she should inaugurate or aid in a purposeful health and accident prevention program. It is by establishing the confidence of the employees generally and of the injured man in particular that she will be able to obtain information which may be of value to the management in

regard to the causes of accidental injuries. It is necessary that the question of negligence be established where it exists, and a quiet and skillful investigation immediately following the accident will enable the nurse to obtain this data and educate the worker regarding its avoidance in the future. The question of fatigue in relation to the incidence of accidents in industrial life is an intriguing one. Statistical records of the time during the working shift when the majority of accidents occur would be interesting in determining the effect of fatigue as a contributing cause of injury. A careful check-up of this factor by the nurse would establish its importance, if any, in the picture.

One thing the nurse should avoid in her work, and that is preaching. Advice given in the form of information will be more readily accepted. Scolding must be entirely avoided.

The industrial nurse should be willing at all times to coöperate with the community nurse, school nurse, and social worker. The problem of coördination of industrial nursing with the service of other workers in the field of health and social work is important. Round-table discussions of these problems should have a place in meetings held by nurses' organizations.

To summarize, the nurse has a responsibility to her community in meeting the problems of health and safety in the home, the school, and industry. There is still much to be done in order that she may contribute her full measure to the solution of these problems which are of such vital importance to human welfare. Professional men and women should dedicate their best efforts to a constant analysis of these needs and a continued search for broader and better avenues of service.

Presented at the nurses' section of the Fox River Valley and Lake Shore Safety Conference, Green Bay, Wisconsin, May 26, 1938.

Selection of Students for Affiliation

A report of the Subcommittee on Student Affiliation of the N.O.P.H.N. Education Committee, January 1939

IN VIEW of the fact that public health nursing agencies limited by personnel and available teaching material cannot offer affiliation to all interested groups, the Collegiate Council on Public Health Nursing Education asked the Education Committee of the National Organization for Public Health Nursing to study this problem. The Education Committee requested a subcommittee to consider the responsibility of public health nursing agencies to three groups: postgraduate students, undergraduate students, and the faculty and staff members of schools of nursing.

The National League of Nursing Education at the request of the Education Committee of the N.O.P.H.N. appointed the following representatives to meet with the Subcommittee on Student Affiliation to represent the viewpoint of the schools of nursing:

Faye Crabbe	Margaret E. Conrad
Blanche Edwards	Miriam Ames

The N.O.P.H.N. representatives are:

Ruth W. Hubbard, *Chairman*

Harriet Frost	Irma Reeve
Lilly Harman	Agnes Ohlson
Elizabeth Fox	Edith Granger

Following are the recommendations of this subcommittee:

This committee believes that a period of field practice in one or more public

health nursing agencies is essential for students taking postgraduate work in public health nursing in a college or university; and that because of the increasing demand from colleges and universities, this group should have preference over the undergraduate student.

The committee believes also that a program of integration of the social and health aspects of nursing throughout the basic curriculum is vitally important to every undergraduate student nurse, and that in addition, a period of student experience in a public health nursing agency is desirable when it can be adequately provided. The committee recognizes, however, that it is impossible for most public health nursing agencies to offer affiliations to all students of all schools of nursing in the community.

The committee, therefore, makes the following recommendations regarding the most effective use of the practice fields when a selection of students must be made. It recommends:

1. That inasmuch as field experience is essential for the graduate nurse students who are preparing for public health nursing, preference be given to that group.

2. That affiliation be offered only to those undergraduate students from schools of nursing which are making serious efforts toward meeting the requirements of the Revised Curriculum Guide for Schools of Nursing and the recommendations of the Education Committee of the N.O.P.H.N. for student affiliation.

3. That the requirements (under 2) be considered a goal to be adopted eventually as a basis for the selection of postgraduate students for field practice in public health nursing.

4. That for those undergraduate students for whom affiliation is not available, a program may be worked out in coöperation with the hospital social service department or the local public health nursing agency or both, to give the student an appreciation of the health needs of the patient, his family, the community, and the resources offered by the community to help the hospital in restoring the patient to health. This plan may involve (1) visiting in the homes of selected families with a public health nurse in the local agency or with a social worker (2) participation with public health nurses and social workers in conferences on family studies (3) one or two days' observation in the public health nursing agency.

Prerequisite to this program is the provision for a well prepared public health nurse on the nursing school faculty.

In addition it is recognized that at the present time head nurses and supervisors need further preparation in order to teach the health aspects of nursing in the undergraduate curriculum and to correlate this teaching with the experience of student affiliation in the public health nursing agency. A short period of experience in the public health nursing agency is desirable for the head nurses and supervisors who have not had this affiliation. However, it is questionable whether such experience should be offered if it limits the opportunity for affiliation of eligible students who will be the head nurses and faculty members of the near future. In other words, students from schools where sound integration of public health occurs in the curriculum would receive consideration rather than supervisors and head nurses from schools without such a program.

Therefore the committee recommends for this group:

That a coöperative program of joint seminars and observations in the public health nursing field be tried out by nursing schools and public health nursing agencies and the results be studied as a basis for further recommendations.

RUTH W. HUBBARD, *Chairman*

Published in *The American Journal of Nursing*, April 1939.

New York's District Health Committees

By MARY ARNOLD

The health department of a great city develops intelligent citizen participation in its program by the organization of a district health committee in each local area

REAL community participation in public health work in New York City started in 1929, when the commissioner of health called leaders in health and social welfare into conference and organized the Committee on Neighborhood Health Development to assist him in promoting district health centers. This committee has functioned actively for many years and has played a very important part in the development of the thirty health center districts in this great city, in the securing of full-time district health officers, and in the program for erecting thirty health center buildings.

New York City's population of seven million people has been divided into thirty health center districts, each with a population of from two hundred thousand to two hundred and fifty thousand. The Department of Health through its Bureau on District Health Administration has appointed a health officer and staff to be responsible for administering the public health program in each district. Through municipal appropriations with federal assistance, the city now has ten health centers housing the local activities of the Department of Health and giving office space to many welfare agencies. Two additional health centers are under construction and three more are being provided for in the budget.

The Committee on Neighborhood Health Development has for some time realized the value of extending into each district its work of creating community understanding and support of the health department's program. The need has been recognized for creating some specific district machinery around each health center to act as a vitalizing force and give its citizens an opportunity to inquire into, defend, criticize, and supplement the work of the health department.

Neighborhoods change and needs vary from year to year, but with an enlightened citizenship and real community understanding of local problems and the functions of a health center, programs will be more readily adjusted to meet new conditions.

DISTRICT HEALTH COMMITTEES

The Department of Health saw in the opening of the new buildings an opportunity for arousing the interest of people in each neighborhood and securing their coöperation. It asked the Committee on Neighborhood Health Development to put into effect a plan for organizing district health committees, which had been under consideration for some time.

A new Committee on Neighborhood Organization was created by the Committee on Neighborhood Health Development, to be responsible for formulating the general policies in regard to district health committees and for advising and aiding in their development. The new committee was composed of fifteen representatives from the medical, dental, and nursing groups, the social work

group, the voluntary health agencies, the board of education, and the welfare council.

There are now five district health committees fully organized, with five outstanding citizens appointed as chairmen by the commissioner of health.

PARTICIPATION ON COMMITTEES

Over eight hundred people are actively participating in committee work, many of them serving on one or more committees. They include doctors, dentists, nurses, social workers, bankers, industrialists, labor representatives, parents, prominent citizens, educators, and representatives of other municipal departments. This ever-growing body of citizens works enthusiastically with the health officers, supervising nurses, and staff members of the Department of Health in interpreting the idea of district health administration to their respective communities. They take an active interest and part in every phase of the local health program, and develop close working relationships with community groups and agencies. The health department's effort to reach out and take the community into partnership has met with a gratifying response.

Under each district committee there is an executive committee. Five subcommittees are also organized, on maternal and child care, school health, tuberculosis, social hygiene, and health education. In several districts, special committees have been appointed, such as industrial hygiene, hospitals, and mental hygiene. In addition there are innumerable small working committees of two or three members under each of the subcommittees. In all, between fifty and sixty active groups are operating in the five districts. The following table shows the division of interests:

Committee	Members
Maternal and child care	131
School health	224
Tuberculosis	123
Social hygiene	114
Health education	142

Busy specialists are willingly giving their time and leadership on the small functional committees which consider problems affecting their own activities. In addition an attempt has been made to secure as members on these subcommittees the field and clinic workers facing the daily problems in fields of tuberculosis, social hygiene, and maternal and child care.

There has developed in each one of the health center buildings a very definite feeling not only of community responsibility for the local program of the Department of Health but of friendly partnership in the program. The terms, "Our health center," "Our health officer," "Our nurses," and "Our clinics" are constantly heard. The extension of these clinic services and the increased use of the buildings play a major part in the programs of the various committees.

The health officer presents at each committee meeting the problems of the district in the health service under consideration and thus strikes a keynote for the committee's planning. The coöperation of the community is shown by the active and enthusiastic support not only of the members of various organizations but of the official representatives of councils of social agencies. The district health committees act as the health committees of the various councils. In order that these local committees may become the means of promoting all types of health programs on a district basis, there has been developed a close tie-up between them and the city-wide organizations.

PROGRAM BASED ON LOCAL NEEDS

Each district committee develops its own program to meet local needs and the wide variation of committee activities demonstrates the wisdom of this policy. For instance, in one borough of the city the committee on health education has carried on an intensive cleanliness campaign to reach druggists, dairymen, deli-

catessen owners, grocers, and bakers. Twenty housewives carried the pledge posters to the local tradesmen for window display. The schools, libraries, and industries were responsible for reaching the people.

In another borough, the health education committee organized health education clinics which were held in five different sections of the district on five successive days. These clinics held twenty-eight sessions over a period of two months. Seventy-five thousand announcements of the clinics were published by a local bank and sent through the board of trade to local merchants for distribution. The announcements laid emphasis on: "Come, see, and ask questions."

Another health education committee assumed responsibility for a "Your health" column in the local weekly paper. Committee members, doctors, and dentists in the district supplied the articles.

Other committees show equal variety in the programs undertaken. Each is chosen because of the local conditions in the neighborhood. The methods used have varied but they can be described under the following headings:

1. Intensive campaigns: attacking special hazards over a limited length of time, reaching into every organized group, and bringing citizens in to take an active part. The five functional committees are used as contact mediums spreading out into the districts through their members, the organizations they represent, and the people they serve.

2. Lectures, developing special courses: (*a*) for special groups such as teachers, social workers, et cetera, stimulating them in turn to carry the health message into the home and providing them with new methods of approach (*b*) for the general public.

3. Correlation: bringing groups, agencies, and individuals together, charting programs in which each plays a part—such as raising standards of service, securing needed facilities, stimulating the use of services in the neighborhood, learning the value of each other's job and the need for close tie-up of services.

4. Interpretation: creating the machinery for bringing the workers and citizens of the district into an intimate working relationship with the staff of the health department; showing the need for the support and coöperation of citizens; extending the use of the services of the health department; developing a community responsibility for and understanding of the health department's work.

The organizing of district health committees has not been able to keep pace with the Department of Health's program of opening new health centers, but plans for rapid extension of the committees are under way.

In order to make the committees function effectively and to secure the leadership and time of outstanding leaders in each district, it is necessary to provide well qualified and thoroughly trained field secretaries with adequate stenographic help so that plans initiated by committees may be carried through successfully. Part-time secretarial service has been provided by the Committee on Neighborhood Health Development for the first five committees. After a year's experience it has become apparent that full-time field secretaries are needed in some districts; in others, the committee activities can be adequately carried on by one field secretary who carries the committee work in two adjacent districts.

Coöperation is a very much overworked term, but to see it grow is a thrilling experience. Pulling together with a common objective and pooling resources for a given goal are currents which when started create challenges that cannot be easily overlooked. New York City has started on a great adventure. It is teaming the staff members of the health department and its interested citizens together in a program directed to secure better health for all its people.

NOTE: See "Committee on the Use of Lay Committees," page 196.

The Nurse Goes to Camp

By LULU ST. CLAIR, R.N.

From coast to coast, eager children are agog with plans for vacation camping. The nurse's responsibilities in a camp are discussed by a nurse with extensive camp experience

THOUSANDS of boys and girls throughout the country are counting the days until they will be going to camp. Ten to fifteen thousand camp directors are selecting camp staffs and making all the arrangements "for the best camp season we have ever had." It is estimated that between seven and ten thousand nurses will be included in the camp personnel selected for the season of 1939.

Camping has long since ceased to be considered a luxury. There is a trend toward the inclusion of camp experience as a part of the educational program for every child—not alone for the privileged few—and toward a more definite correlation of the camping program and the school program. There are two extremes of group thinking among the leaders of schools and camps, according to Herbert H. Twining, President of the American Camping Association. The camp-director group is alarmed by the part played by schools and universities in camping. The school group believes that camp experience should supplement school experience and that camp programs should be patterned after those of schools. By all groups there is a recognition of the fact that camping offers a valuable contribution to education because of its informal type of program. Mr. Twining states, "With the variety of sponsoring agencies working in the camping field today, the basic sponsorship for the camps of the future is assured. There will, of course, be new groups coming into the picture sponsoring their own camps, but the general increase in the numbers of camps will be within the range of the present sponsoring groups.*

TYPES OF CAMPS

Camps may be roughly classified as private, semi-private, and governmental camps. The private camp, owned and conducted by an individual or group, is usually small and is generally maintained for profit. These camps require tuition, and pay better salaries to their personnel than do other types of camps. The children usually remain for the entire season which is six to eight weeks. Such a camp may be for boys or girls, or both boys and girls. Many of the camps are specialized in that they admit only children with special problems such as speech defects, orthopedic defects, nutritional problems, or diabetes.

Semi-private camps sponsored by the Boy Scouts, Girl Scouts, Camp Fire Girls, Young Men's Christian Association, Young Women's Christian Association, and other recreational and welfare organizations are frequently larger and usually admit children for shorter periods of time. They are often conducted as a part of the yearly programs of these community agencies. Part of the cost of maintenance may be paid by the parents. There may be specialized camps within this group, such as the type of camp sponsored by tuberculosis associa-

*Twining, Herbert H. "Camps of the Future." *The Nation's Schools,* June 1938, pp. 37-38.

Courtesy of W. K. Kellogg Foundation

Children showing symptoms of illness rest in the camp infirmary until the doctor comes

tions for children who are tuberculosis contacts.

Recently the Federal Government has developed a camping program in its organization of the Civilian Conservation Camps under the United States Army. These camps were later put in the hands of trained foresters and conservationists. While a great deal of their program has consisted of conservation projects, over two million boys have received educational experiences which have enabled many of them to go on with higher education or learn a trade.

The National Park Service has made available some of its submarginal agricultural land to establish a number of camps. These camping facilities are rented to such groups as Boy Scouts, 4-H Clubs, churches, and others for a low cost.

With groups of school people interested in the potentialities of camps as part of the educational institutions of the future, it seems probable that there will be greater developments in camps under the auspices of government agencies such as schools and municipalities. There are already a number of such camps conducted on a year-round basis.

CAMP PROGRAMS

A camp should offer a well rounded program of character building, health education, and preparation in the use of leisure time. Some of the major activities by which these objectives are attained are: daily regular routines of health activities including eating, sleeping, resting, and bathing; camp housekeeping; nature lore; handicrafts; dramatics, music, and dancing; games; hiking; pioneering; watercrafts.

Each counselor has under his or her charge a group of from seven to twenty children. Where the ratio of campers to counselors is small, the counselor may sleep in the cabin or cottage with the children and acts as hostess at their table in the dining room. In the camps where there are a larger number of children to a few counselors, the latter may

When the "buddy whistle" blows every child raises his hand with his buddy. No one is missing

sleep nearby. In either case the counselor is both a teacher and a parent substitute for the child while he is at camp.

QUALIFICATIONS OF PERSONNEL

Many organizations require their counselors to have preparation in child psychology, camping methods, and problems of personnel adjustment. Courses are now being offered in colleges and universities for preparation for camp work. No qualifications have as yet been outlined for nurses in camp nursing positions, but it is reasonable to expect that nurses should have preparation that will enable them to make a valuable contribution to the modern well organized camp program.

Nurses who are engaged in private duty and school nursing or hold other types of positions which make it possible for them to be free during the summer months are the usual recruits for camp nursing positions. The director of Nurse Placement Service (8 South Michigan Avenue, Chicago, Illinois) states that the greatest demand is for nurses with a public health nursing background and experience in school nursing.

The type of work which the camp nurse does parallels very closely that of the school nurse. The minimum qualifications* for nurses appointed to school

Children see the nurse at scheduled hours

Courtesy of W. K. Kellogg Foundation

*National Organization for Public Health Nursing. "Minimum Qualications for Nurses Appointed to School Nursing Positions." PUBLIC HEALTH NURSING, February 1938. Reprints free.

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nursing positions as outlined by the National Organization for Public Health Nursing might serve as a basis for the selection of a suitable camp nurse. With the prospect of future development in camp programs it seems likely that the demand for adequately prepared nurses will continue to increase. In view of the requirements made by directors requesting the assistance of placement agencies in securing suitable camp nurses, nurses who are seeking employment in camps should offer the following qualifications:

> Good health; interest in and liking for children; ability to work with others; ability to recognize and take advantage of opportunities for health teaching; good basic preparation in pediatrics; a sound course in child psychology.

It goes without saying that the nurse must be enthusiastic about outdoor life.

FUNCTIONS OF THE CAMP NURSE

The duties of the nurse depend upon the kind of camp, the type of camp program, and the number of children who are cared for. If the camp is small the nurse may be asked to assist with other phases of the camp program besides health. If she has talents such as dramatic or musical ability, or a background in nature lore, she may be drafted to assist with those activities or carry the responsibility for them. She may serve as assistant to the director or she may be called upon to help in planning the menus and buying the food. In the larger camps each phase of the camp program is often under the direction of someone especially fitted for that type of work and the nurse is held responsible only for the health aspects of the program.

Some larger camps also employ a resident doctor. When there is not a physician in residence the director will make arrangements with a physician located nearby for periodic visits to the camp and for medical care in emergencies. If a physician is a member of the camp staff he assumes primary responsibility for the health aspects of the program and usually teaches first aid. There should be an understanding regarding what are the nurse's responsibilities in certain situations in his absence. If there is no physician at the camp the nurse secures from the doctor who is selected by the director, standing orders to guide her in the care of minor ailments and emergencies. These orders include first-aid treatment of such conditions as poison ivy, mosquito bites, sunburn, abrasions, sprained ankle, toothache, and suspected communicable disease.

Before camp begins the nurse should see that provision is made for standard first-aid equipment, simple remedies, and appliances. Those listed in the American Red Cross texts on home hygiene and first-aid are suitable.* In addition to these she will see that necessary supplies, as recommended by the physician responsible for the medical aspect of the program, are obtained. The infirmary will be equipped with cots or beds and other simple sickroom appliances. The nurse is directly responsible for its management.

The nurse usually wears camping clothes on duty, with perhaps white or light sport clothes for visiting days. This type of costume is much more appropriate to the needs of the camp situation than a regular nursing uniform.

Precamp conferences of camp personnel are held by most camps to discuss the program which is planned. The nurse is held responsible for seeing that the camp staff, especially the counselors, understand the routine in relation to her functions. They usually include the following procedures:

Precamp medical examinations of the

*Delano, Jane A. The American Red Cross Text-book on Home Hygiene and Care of the Sick. P. Blakiston's Son and Company Philadelphia, fourth edition, 1933.

The American Red Cross. First Aid Textbook. P. Blakiston's Son and Company, Philadelphia, revised 1937.

children with reports on a form provided by the camp are almost a universal requirement. Such examinations are made by the family physician; in the case of camps under organizations, perhaps by a physician employed by the organization; or in places where the camp is sponsored by a school, perhaps by the school physician. Upon entrance to camp the children report in groups to the infirmary accompanied by their counselors. The nurse, assisted by the counselor, weighs the children and checks their health records, noting any special advice recorded by the physician giving the precamp physical examination.

Information or instruction regarding any limitation of activity for individual children is given to those in charge of that activity: for example, a list of children whose swimming activities are limited is given to the person in charge of waterfront activity; or a list of the children who with orders from their physicians for special diet or extra nourishment is given to the dietitian or to the person responsible for serving the food.

Children are usually weighed again at the end of the camp period; if the period is longer than two weeks, they may be weighed oftener.

Office hours are usually scheduled each day after breakfast and after supper. During this period the children report for first-aid treatment of conditions such as insect bites, poison ivy, and sunburn, and for a change of dressings when needed. Children with special symptoms or problems are seen at this time. Although an effort is made to care for most of the needs during office hours, children needing emergency care are brought to the infirmary whenever necessary.

The nurse is responsible for inauguration of a regimen for the prevention of sunburn, with careful instructions to the counselors regarding the rigid program to be followed. The children must be exposed gradually. On the first day they keep the skin covered except during the swimming hour. The period of exposure is then lengthened a little each day.

It is the custom in many camps that children going on an overnight hike, a long canoe trip, or some pioneering excursion where they may be gone longer than a day must be checked by the nurse for elevation of temperature, and signs of cold, or fatigue, before they are permitted to go.

The nurse will instruct the counselors what to do in emergencies when they are out of camp with groups of children, and what are the common signs of communicable diseases for which they should be watchful.

The nurse should assist the counselors in the integration of health teaching in all the activities planned for the children as part of the camp program.

The nurse also acts as a health counselor to the counselors and others of the camp staff. Here alone lie some excellent opportunities for teaching future teachers, community workers, and parents.

The nurse should be familiar with the state sanitary code in regard to camps. She should know the sources of water and milk supply for the camp and whether they meet the standards of the local and state health departments. The protection of the safety of the entire camp will be substantially increased by insisting on the use of pasteurized milk wherever possible. The nurse may be required to function as the sanitary inspector of the camp, and she should know whether the method of sewage disposal is safe and whether the garbage disposal and insect control are satisfactory. Information on these questions may be secured by writing the state department of health. She should know whether the kitchen employees have had the examination for food handlers required by the health department. Any violation of good sanitary procedures

Courtesy of W. K. Kellogg Foundation

Treatments ordered by the physician are given by the physical therapist on the beach

should be called to the attention of the camp director. Excellent opportunities for health teaching by the nurse are presented in this phase of camp living.

The nurse does not leave the camp at any time unless there is a doctor in camp or unless she is within easy calling distance and can be secured within from fifteen to thirty minutes. She has a day or a half-day off each week if there is a doctor in camp. Otherwise she has only the period between the departure of one group of children and the admission of a new group.

NURSE'S CONTRIBUTION TO PROGRAM

If a child is in camp for eight weeks he has spent about as many hours there as he spent in school for a whole year. Unfortunately, there are a great many

While the children play water games they are guarded by Red Cross lifesavers

Two lifesavers are with the children while they learn to paddle a war canoe

children who do not have the privilege of this period in camp. However, if a child spends only two weeks in camp, which is the length of the period in many camps, he will spend as many waking hours there as he would in a fourth of his year at school.

A well qualified public health nurse can make a valuable contribution to the health education program of the camp. This is especially true if she had had experience in teaching and in dealing with school health problems. She has knowledge of the health needs of normal children as well as those of handicapped or under-par children. She has had experience in detecting early signs of communicable disease. She is alert to opportunities for health teaching, and she has had experience in guiding others who are directly responsible for the daily routines for children. She can assist counselors who are in charge of the children twenty-four hours a day and who are acting as both teachers and parents to the children during the time they spend in camp. With the controlled environment provided by the camp in regularity of schedule, rising, retiring, rest, and meals, an excellent opportunity is afforded for child study, health teaching, and habit training under ideal conditions.

Fortunate indeed is the camp director who can secure for his camp nurse one who functions as school nurse in the same community from which the boys and girls come. She is familiar with their health problems. She can use her influence to see that children are well prepared for camp. (What is more tragic than a child at camp with a toothache!)

A young archer learns to pull the bow

She also can follow the child afterward, interpreting the health program of the camp to the teacher in school and to the family.

Eight-year-old Mary was always tired and looked thin. She did not enter into play activities in school with any enthusiasm. Her school schedule included a one-hour rest period but she rebelled against that. The mother told the school nurse that Mary would not drink milk. The nurse had frequently suggested ways by which the child might become interested in eating the kind of food she needed. Apparently the mother was giving in to the child and pampering her. When the nurse made up her list of children to go to camp she included Mary's name. After much persuasion Mary's mother gave permission for the child to go though she did not know what she would do without her "for four long weeks." Fortunately, the school nurse also went to camp as the camp nurse. She talked with Mary's counselor about the child's home background. They decided that Mary might have refused food, especially milk, to get attention, and that she must realize that this just would not work at camp.

At the first meal Mary did not eat her vegetables or drink her milk. The other children did. The counselor casually asked Mary if she were not going to eat her food. She replied that she would eat her dessert. The counselor explained the camp rule that persons who did not eat their vegetables and drink their milk did not have dessert. Mary was stubborn. She pouted but the counselor paid no attention, and Mary had no dessert. When she discovered that it apparently made no difference to anyone whether she ate or not, and she was the only one who suffered, she became a hearty eater. The outdoor activity made her hungry which also hastened her conversion.

The same principle applied to resting. There was no fun in not resting since everyone else was doing it and no one seemed to care whether she rested or not. Mary looked like a different child when she left camp. In September after school began and the school nurse was in her office preparing the list of children for rest-room periods, Mary appeared and said, "Miss Jones, may I rest? You know I always did at camp." Mary's mother wrote Miss Jones a letter asking if she would please find out how they cooked carrots at camp. Mary looked forward to camp the next year because she wanted to swim twice a day instead of just once as she had the first summer.

This is an example of what may be accomplished by a nurse with some understanding of child behavior and ability to give the proper guidance to a counselor in handling health problems.

THE PROBLEM OF BED-WETTING

Bed-wetting in camp is always an annoying problem and rubber sheets to protect the mattresses of children who wet the bed are a necessary part of camp equipment. Counselors frequently ask the nurse what can be done about this problem. At one camp the following scheme has been successful: A list of bed-wetters was kept by the nurse. Each morning these children were given the responsibility of reporting to the nurse. (The children always delight in going to see the nurse.) If the child had had a dry night the nurse put a mark after his name; if not, the space was left blank. It was explained that there should be a mark for every dry night at camp. The children usually counted up the number they would like to have so they could go home and tell their mothers. But they were not scolded when they reported a wet bed. The nurse usually remarked casually, "That's too bad. I'm sure you'll have a better report tomorrow." When a good report was made the child was praised. The nurse and the counselor skillfully shifted the responsibility for a dry bed to the child himself. The percentage of dry beds in camp went up. It has been found that bed-wetting is frequently due to emotional conflicts and tensions in a child's life. Often the child gets away from these tensions at camp, with the result that the symptoms disappear.

Some camps admit a few mildly handicapped or under-par children. A skillful nurse will be able to advise the counselors how to make adjustments in the camp program so that these children will feel they are like normal children. Provision for additional time for rest, and additional time to get to meals and other camp activities must be made. Handi-

capped children must have some special help but not enough to make them too dependent.

Two little crippled girls, Mary and Lucy, wanted to participate in rhythms. Mary had braces on both legs and Lucy had a mild spastic paralysis. The nurse and counselor conferred on the problem. Tom-toms were provided, and Mary and Lucy became part of the orchestra. They felt very necessary to the rhythm group.

. . . . .

Billy, a bright little boy of eight with spastic paralysis, was small for his age. He had been overprotected at home and perhaps also at school. At camp everyone tried to help him. All at once he asserted his independence and declared he did not like his counselor because the counselor always wanted to carry him. The nurse worked out a plan with the counselor that would allow Billy to start fifteen minutes earlier to get his meals. It was amazing how much better Billy could walk at the end of several weeks of camp.

In order to plan and carry out a successful camp health program there must be coöperation among all the camp staff. The nurse should be responsible for seeing that counselors realize the importance of being observant of any deviation from the normal among children.

The buses bringing the children to camp were unloading. The counselors were greeting the children. Seven-year-old Jane was not feeling well. Since the children were presumably inspected before coming to camp, Jane's upset stomach might have been attributed to the excitement of anticipation and the long bus ride. However, a counselor immediately took her to the infirmary. The nurse had her lie down. The child's face, neck, and chest were flushed and her temperature was 102°F. The nurse called the doctor and asked the head counselor to see that all the children who rode on the same bus were isolated. The doctor said the child had scarlet fever. Jane's parents were notified to come for her. The mother stated that the child was not feeling well when she left home. It was thought, however, that she just had an upset stomach, and since her parents hated to disappoint her about camp, they let her come. The parents of all the children who rode in the same bus were notified that the children had been exposed to scarlet fever and they were asked to choose between leaving them at camp under the supervision of the nurse, or taking them home. Two exposed children went home and the others remained at camp but were carefully watched. On the fourth day the girl who had sat in the same seat with Jane complained of a mild sore throat, looked flushed, and had a slight elevation of temperature. She was taken home at once and had a mild case of scarlet fever. It was later learned that one of the two children taken home at the beginning had had a mild case also.

These stories show what opportunities may be presented to the camp nurse to make real contributions to the health protection and health teaching of the children and how important it is for camp directors to secure as camp nurses those who are keen and alert and attuned to the type of work expected of them.

DEMAND FOR CAMP NURSES

It has been estimated that about 70 percent of camps in the country employ nurses. The director of Nurse Placement Service states that the demand for camp nurses was increasing steadily up to 1929. At the present time the demand is again on the upswing.

The salaries in summer camps vary from maintenance only, to $300 and maintenance for the entire season, 4 to 10 weeks. In camps that operate on a year-round basis the nurses' salaries may run as high as $150 a month with maintenance.

A nurse who seeks a summer camp position because it may afford her a pleasant vacation, restore her tired body and mind, and replenish her pocketbook, courts disillusion. The work is some-

times light, sometimes heavy; but the nurse must be available twenty-four hours a day.

For the nurse who likes children, enjoys outdoor activities, sees an opportunity for interesting and valuable experience, and can offer the qualifications mentioned earlier, a summer at a children's camp offers a thrilling and satisfying interlude in her life.

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Trends in School Health Examinations

By CHARLES C. WILSON, M.D. AND HELEN M. CLANCY, R.N.

School health programs are not static. They change with changing concepts of education and public health. Four trends in school health examinations today are described here

HEALTH EXAMINATIONS are now considered an essential part of all school health programs. Parents expect that such examinations will be made. Teachers are asking that they be informed of defects in seeing or hearing which may interfere with the academic accomplishments of their pupils, and conditions which may limit or modify their recreation programs. Despite this common acceptance of school health examinations, the procedures used and the end results attained are continually being scrutinized by educators, school health workers, health officials, parents, and others. As a result of this scrutiny and study, it is quite likely that future school health examinations will be as different from those of today as today's examinations are different from those of a decade or two ago.

The school health examination of former years was primarily an inspection to detect the presence of contagious disease and was planned particularly as a communicable disease-control measure. For this purpose it was practically a failure and was supplanted by the daily inspection of pupils by teachers and nurses. Health examinations were continued, however, because it was found that through them pupils in need of medical and dental care were discovered and because unsuspected remediable defects were revealed. Various objectives and procedures for health examinations have been suggested and tried in different communities, and it is impossible to predict the exact form of future procedures; but it is enlightening to note some of the present trends.

Four trends or emphases in school health examinations will be discussed here. These trends are:

1. To emphasize the educational implications of the examination and the nurse's follow-up of examinations.
2. To encourage examinations by private physicians.
3. To favor less frequent but more thorough examinations.
4. To emphasize the need for day-by-day observations of pupils by parents and teachers as a supplement to periodic health examinations.

EDUCATIONAL IMPLICATIONS

The educative value of health examinations is being discussed by educators and physicians. The educator is thinking of education as a group of planned experiences. In this light he regards the health examinations as a planned pupil experience from which it is expected the child will learn certain facts about health and about physicians. The physician thinks of the educative influence of the examination because he has learned that pupils' attitudes toward the entire medical profession and pupils' concepts of the value of health examinations may be greatly influenced by the attitude of the school physician, his method of making the examination, and his comments to pupil and parent.

One angle of this subject is illustrated

by the experience of a school physician who was assigned for service at a high school. The principal requested the examination of a particular boy because of rather frequent absences supposedly due to sickness and because of poor school progress which he thought might have a physical basis. The examination was made and the physician reported his findings to the principal. He was somewhat surprised when the principal said, "Did you know that while you were examining that boy, he was examining you?" When asked to elaborate, the principal continued, "He thinks you are a considerate man. You did not embarrass him when he couldn't answer your questions. He appreciated your telling him why you listened over different parts of the chest, as well as the suggestions you gave him about sleep and rest. All in all, he thought you were quite friendly and helpful." Whether we wish it or not, pupils as they are examined will develop attitudes and ideas about physicians and about health examinations.

Likewise, the school nurse in her work is applying the basic tenets of the newer psychology and social philosophy. The school no longer sets up its aims in the form of prescribed general and specific objectives to be mastered by the children but rather in terms of the life aims of human beings. Learning and living are synonymous terms. Moreover, it is known that a knowledge of the whole child is not arrived at through a minute analysis in terms of defects to be corrected, but is to be gained only through an understanding of the child in relation to his total environment.

With these concepts in mind, the school nurse uses every contact with a child or a parent as a teaching situation. In her follow-up work she is no longer concerned merely with the correction of a defect discovered at the time of the child's physical examination. She sees that her contacts with child and parent may often be measured in more valuable though less tangible outcomes.

It is the school nurse—particularly at the elementary-school level—who more frequently than any other member of the school staff has contact with the parents. Such conferences, either at the school or in the home, are planned as painstakingly as any other educational endeavor the school undertakes. Parental coöperation is more easily secured if the parent is present at the time of the child's health examination.

STIMULATING PARENT INITIATIVE

Schools are tending to capitalize on the interest of the large numbers of parents of kindergarten and first-grade children who come to the school for the child's first physical examination, by examining all the children in the same family at the same time. The advantage of such a procedure is easily seen. The first part of the interview is given over to the establishment of rapport with the parent. Frequently only one child in the family has a condition for which further medical follow-up is needed. The parent has been made to feel that she is taking an active part in the discovery of such a defect. Playing such a role, she is more apt to take the initiative in securing medical care for the condition than if the school, through a notification slip, informed her of the defect some time following the child's examination.

At the high-school level the school nurse plays an important role in the guidance program. Changes in educational objectives and methods at this level too have resulted in the school's being concerned about the individual needs and development of its pupils. Furthermore, pupils of this age are self-directing and show great concern about their health problems. These two characteristics do not suffice to motivate action on the part of a particular child; but the nurse in her conference takes cognizance of them and attempts to di-

rect the child's thinking into those channels which will bring about the most desirable attitudes and behavior in terms of his own good health.

THE PRIVATE PHYSICIAN

There is a growing and desirable tendency for schools to encourage parents to have pupils examined by their private physician. Undoubtedly there have been varying motives for this step in different communities. One does it because it makes pupils and parents less dependent on the school for medical advice. In other words, it is an educational device to set a pattern of relying on the private physician for health advice. This is a pattern which can be followed seven days a week, each week of the year, and can be continued after the pupil has left school. Another community encourages examinations by private physicians so that the school physician will have more time for examining other children needing special attention. A neighboring school does it as a coöperative measure with the county medical society because of the realization that school health examinations are limited in scope and ordinarily cannot include some of the laboratory measures which the private physician can carry out in his office. Regardless of the motive, the policy of encouraging examinations by private physicians has received emphasis during the past few years and is considered by most school health workers as a desirable trend.

Where examinations by private physicians are sponsored by the school health program, it is customary for the school to supply an examination form which, after being filled out by the physician, is returned to the school. The form usually has a place to record preventive treatments such as diphtheria immunization and smallpox vaccination, and suggested limitations or modifications of the school program.

From a wholesome attitude of questioning how frequently school health examinations should be made, there seems to be developing an attitude of favoring less frequent but more thorough school health examinations.

FREQUENCY OF EXAMINATIONS

It should be quite clear that at the present time we have no scientific data which will tell us whether school examinations should be given every month, every six months, every year, every two years, or every four years. In order to get a scientific answer to the question, records must be kept to indicate the *new* conditions which are found at each examination, separate from conditions which were known previously. We shall also have to consider the educational purpose of the examination and find an answer to the question, how often is a health examination desired as an educational experience? After accumulating these data, we shall have to consider the cost to determine whether the anticipated gains are commensurate.

Where attempts have been made to examine each pupil every year, many of the examinations have been hurried, careless, and practically valueless from the medical point of view.

It is also pertinent to point out the definite limitations of health examinations by calling attention to the fact that serious sickness may develop the day after a thorough, careful examination revealed no abnormality. Those who consider that negative findings assure continued good health are laboring under a false sense of security. Physical examinations will reveal conditions as they exist at the time of examination, but they cannot tell what will happen in the future. As a means of finding pupils who are in need of medical care, the health examination is also quite limited. The pupil with a communicable disease, a pain in the abdomen, a headache, or blurred vision all need medical care; but all of these conditions can occur soon

after an examination and with no marking on the health examination card to give warning of their approach.

It is the belief of many that four routine school-sponsored examinations by a physician during the school life of a pupil—two in the elementary and two in the secondary period—are sufficient to discharge the school's responsibility. These four examinations—together with the day-by-day observations of pupils by parents and teachers, and arrangements for securing further examination and medical care when needed—should detect most abnormal conditions affecting growth, health, and school progress. They should also afford teachers the information necessary for understanding their pupils and adjusting school programs to their needs.

DAY-BY-DAY OBSERVATIONS

The limitations of health examinations in finding pupils in need of medical care were mentioned above. Because of these limitations, we find that considerable emphasis is now being placed on the day-by-day observation of pupils by parents and teachers and careful procedures are being developed so that parents and teachers will know how to refer pupils who show deviation from the normal, for further examination. These things are done so that parents may be guided to sources of treatment.

One important function of the school health program is to direct needy pupils to places where treatment is available. The day-by-day check on pupils' health by teachers gives the school nurse and the school physician a contact with those who seem to need care. Another way of finding pupils in need of care is the check on absences. This is necessary not after a pupil has been out for two or three days but as soon as the absence occurs; if there is sickness, the time to give help is when it starts.

No matter how frequently routine examinations are made, there will always be a need for daily teacher observation of pupils and a plan for referring for further examination pupils who do not grow as expected or who show symptoms of disorder or disease. In many cases the examination of a few pupils referred by teachers gives the school nurse greater opportunity to improve the health of children than many routine examinations. It is because of these tangible results that we see an emphasis on examination of pupils referred by teachers because of a particular problem.

As mentioned at the beginning of this article, school health programs are not static. They change with changes in education and in public health viewpoints. We cannot predict the form of future school health programs. But we feel safe in assuming that safeguarding and promoting the health of school children will continue for many years to challenge the coöperative efforts of school administrators, teachers, school nurses, physicians, dentists, public health officials, and others interested in health.

A GUIDE TO THE SCHOOL NURSE

Four present trends in school health examinations are discussed by a school physician and nurse on page 219.

The need for close coördination between the health service of the school and that of the summer camp is emphasized in an article on camp nursing. Page 209.

Safety in home, school, and industry is discussed by Dr. W. Webber Kelly, who interprets safety in the broad sense as including health protection. Page 201.

Every nurse—and indeed every woman—should be informed on the subject discussed in Dr. Kress' article on page 229.

Preparation of Nursing Aides for the Home

By LEORA B. STROUP, R.N.

An experiment in the training and supervision of home nursing aides, with field experience in homes provided through the Visiting Nurse Association

THE SUBSIDIARY WORKER in the home, trained and supervised by the organized nursing group in the community, fills a definite community need which is not met otherwise. Such a worker—who in Detroit is called a home nursing aide—does work befitting her preparation and ability. She cares for the patient with mild illness, the convalescent, the mother who comes home from the hospital with a new baby, the aged, and the chronically ill. Her place is not with the acutely or seriously ill patient who needs the care of a skilled nurse. The training and placement of the nursing aide has been controlled in Detroit for over twelve years.

Several years ago a Community Nursing Bureau was established in Detroit, Michigan. Such a bureau if it is to serve the community well should be set up to meet all the nursing needs in that community. In order to fill all the calls coming to the bureau from homes, there was a need for a type of service which did not necessarily require a highly skilled, technically prepared graduate nurse.

These homes calling for help needed a type of person who could fit into a home well and get along with members of the family and who could bring order following the disruption caused by the illness. Such a person had to give simple nursing care to the person ill in the home. In an illness which would not take all of her time, she had to be able to meet other needs in the home. She was often responsible for the care of the children; for orderliness, cleanliness, and management of the home; and for the meals, which might include family meals, children's diets, and the invalid tray or special diets for the patient.

COURSE FOR NURSING AIDES

The Community Nursing Bureau received many calls for this type of worker, but it was unwilling to take the responsibility for her placement or endorsement unless it knew more about her. So the bureau decided to offer a course of training and to adopt a policy of placing only those individuals who had successfully completed the course. This was ten years ago. The course was six weeks long and was offered to qualified mature women. As the years have gone by, the course has been modified to meet changing needs. It is now sixteen weeks in length. After completion of the course, the home nursing aide is placed in homes for experience under the supervision of a graduate nurse supervisor. After six months of successful supervised work under the bureau, the student is granted a certificate. It is to her advantage to be placed in homes through the bureau; after completion of her course of instruction.

In the selection of women for the training period, those between 35 and 45 years of age with past experience in managing a home and caring for children are usually the ones chosen. Because of the brevity of the course they must know how to cook before being accepted and must have had experience in house-

hold management also. Preference is given to those who have done some bedside care for the sick in homes. Practically every applicant remarks, "I have always wanted to be a nurse." Emphasis is placed on maturity, experience, judgment, personal qualifications, and health. The applicant is required to have a physical examination made by her personal physician at her own expense. The examination includes an x-ray of the lungs and a Kahn test. Special attention is given to the weight, visual and hearing acuity, and condition of the feet. A report is made on a form provided by the school.

The sixteen-weeks' course covers special training and experience in four subjects: nutrition, household management, care of infants and children, and simple nursing. Classes are all held in a building which is a double house, remodeled and adapted to the needs of the teaching. The entire program is in charge of a graduate nurse who is known as the coördinator.

FIELD EXPERIENCE

It has not as yet been possible to arrange for all students to have experience in an institution under close supervision, nor has the nurses' advisory committee to the program advocated this arrangement especially. It is still under advisement by them. As an alternative, however, a plan has been worked out whereby each student receives actual experience in the field under supervision. This experience is given in two nursery schools; in a private convalescent home where there are four aged ladies; and in homes selected through coöperation with the Visiting Nurse Association. These arrangements for the student to obtain practical experience afford an opportunity for the coördinator from the school to evaluate the student's ability to work and to adapt herself to a typical home situation.

Beginning on Saturday of the second or third week of the course, arrangements are made for each student aide to accompany a visiting nurse for a half day of observation in homes. The homes selected are ones regularly carried by the visiting nurses. This visit gives the student an insight into the homes of other people and how they live. After the fourth week of the course—by which time the students have attained a certain degree of skill—they are placed outside of the school for their field experience. There are usually from 14 to 18 students in a class. Half of the class are in the field for three hours every forenoon for five days. Each afternoon they return to the school and continue their regular class work. During the following week the remaining half of the class get their field experience in the same way. The half of the class whose forenoons are spent at the school have intensive instruction in cooking, management, and elementary nursing procedures.

The routine for placement in the homes is as follows: Calls are taken at the school from the Visiting Nurse Association office or branches. An assignment is given to each student, and the teachers at the school help her plan the schedule on her particular case for the forenoons of the whole week. The student goes out on Monday morning and is in the home when the visiting nurse comes. The visiting nurse either watches the aide give the necessary nursing care or she gives the care while the student aide watches. Thus, the visiting nurse teaches the aide in the home.

The nurse coördinator from the school visits the student aide in the home during the week and also gives help in the teaching and supervising as necessary. The student aide stays in the home three hours each forenoon for five days and does what is necessary to manage the home and to care for the family. In the afternoons she returns to the school to her classes and reports to the teachers her experiences, how her schedule worked, where it did or did not function

successfully, and what problems she encountered in the home.

The visiting nurse keeps in contact with the family and finds out from them what the student aide has done in the home and how well she was liked by the family. Family reports on paper of the aide's work are, however, almost valueless for they do not know the standards by which to judge correctly. The report made by the visiting nurse is most valuable.

When the same homes can be used consecutively from week to week the work is simplified for the coördinator from the school who places the students. The greatest care and attention to every detail must be given in the last-minute instructions to the student aide before she goes to the new case assigned to her, in order to prepare her for what she will do there—especially in regard to general care and specific treatments.

TYPES OF HOMES USED

When it is possible to place the student in the home of a graduate nurse where there is illness, an intelligent report of the aide's work can be obtained. At the present time one such selected home is being used and the staff considers it to be the most valuable one on the list for student experience. It is the type of normal home into which the home nursing aide will be sent when she finishes her course. The aged mother of one of the visiting nurses is the patient and she requires constant care. Every phase of general nursing care and adaptation to a home situation can be practiced, even to learning how to adjust to other help in the home. The student relieves the regular full-time nursing aide over the Saturday and Sunday period each week end.

Another home where the students received excellent experience during one term was the home in which a graduate nurse who was formerly a Red Cross home hygiene instructor was chronically ill herself. She was pleased to have a different student come each week end to her home and she knew so well the points on which to judge the student in her work. Her reports were very valuable as she commented on points such as: "She knew how to improvise"; or "she was too slow"; or "she talked too much."

One typical case assigned through the Visiting Nurse Association was a home in which the mother was ill in bed. There were small children in the home, and an aged grandmother with the help of a fourteen-year-old daughter was trying to carry on the management of the house, the meals, and the nursing care. The student aide finds in such a home typical problems to be worked out in practice. She must organize the work, bring order to the home, and relieve family members of their burden. How she worked out her plan and whether she did the most important things first are determined in conference with her teachers at the school each day when she returns at noon.

The plan for student practice as outlined here works reasonably well and the students do get experience. Perhaps this arrangement is not the best solution to the problem of how to provide practical experience for them; but as a step in the experiment, it has worked splendidly and has many advantages. It provides for training and experience in actual homes and under a variety of conditions. Close supervision is given by a graduate nurse—either a nurse from the Visiting Nurse Association or the coördinator from the school.

Part of the success in the experiment is due to the attitude which the Visiting Nurse Association has toward the whole project. The organization has volunteered to help in the teaching of the aide in the home situation. It recognizes these mature women as the answer to the problem of simple nursing care of the sick in the home. Of course the family and homes are selected carefully by them, and no aide is allowed to care

for acute illness at any time. The visiting nurses all speak highly of the arrangement because they feel so much easier about their families when they know that someone responsible will be in the home between their visits.

There is value to the student aide in the experience of coming to a strange home and of being able to work there and get along with members of the family. The student gains confidence in herself from the experience. The families of course appreciate the service very much. The private physicians speak highly of the arrangement.

COMMUNITY NURSING BUREAU

A community nursing bureau which has on its roster graduate nurses, hourly nurses, male nurses, home nursing aides, and housekeepers trained to meet all types of situations, serves the community better than a bureau which considers the graduate nurse to be the only type of person who can supply what is needed in a home disrupted by illness. Such an arrangement provides the community and physicians with a clearing house through which they can secure persons qualified to serve in the different kinds of situations arising in homes because of illness.

People who buy nursing service in Detroit have the advantage of securing it through the Community Nursing Bureau of the District Nurses' Association. The bureau works closely in coöperation with the Detroit Council on Community Nursing which is composed of members who are interested in the preparation of graduate nurses and home nursing aides and in the distribution of nursing service to meet the needs of any kind of sickness in the community.

Through the nursing council there has been stimulated an active interest and support from representative groups in the city which include hospital administrators, nursing executives, and lay groups. The council is one of the agencies supported by the community fund. The fund provides for a full-time graduate nurse, who acts as supervisor and adviser to the student aides and visits them while they are on duty in the homes.

THEY REPLACE "PRACTICAL NURSES"

The trained home nursing aide, sponsored in her training and work by a community nursing bureau, takes the place of the untrained and unsupervised independently working practical nurse who is at large in the community. Besides fulfilling a nursing need, the project is a blow to the irregularities of the untrained practical nurse who sometimes poses as a graduate nurse, charges her prices or higher, and dresses in some kind of a nursing uniform.

It is difficult to think of any disadvantages of such a subsidiary worker from the standpoint of organized nursing. It is an accepted fact that the public gains more protection when the work of this subsidiary worker is under the supervision of an organization representing graduate nurses. The line between nursing aides and graduate nurses must be consistently maintained. For homes, a combined service of the aide for full-time duty and the visiting nurse for special visits to do special treatments or dressings makes a very satisfactory arrangement for the family which is in need of nursing care but does not require a full-time graduate nurse.

THEY KNOW THEIR LIMITATIONS

These home nursing aides who are trained by graduate nurses are loyal to their sponsors and the principles and standards which they represent. They are happy to be recognized, and are so anxious to be in good standing with their teachers and supervisors that they almost never overstep themselves. They are taught working relationships. They use the best judgment they have when they are in homes. When in doubt they tele-

phone their supervisor at the nursing bureau and she visits them. They do not go out into the community and assume responsibilities for which they are not trained. The next step in Michigan is to get them licensed. This will be done when a sufficient number have been trained to serve the community well.

So far there have been a sufficient number of applicants to the course to make possible the careful selection of students. In the teaching program it has been possible to secure persons who are experts in the field. The project during the past year has been fortunate in having the instruction provided for the school through the State Department of Vocational Education in coöperation with the Detroit Public Schools.

An important part of the program is informing the public about these workers and the limits of their responsibilities in homes. Methods of informing the community include representation on the various committees from the medical society and from members of the community who employ the aides, and talks to groups such as women's clubs and graduate nurse organizations.

This is a progress report which shows some of the advantages and disadvantages of the present plan of work in connection with the subsidiary worker in the home who in Detroit is being called the home nursing aide.

NOTE: See also "The 'Attendant Nurse' in the Home," by Lillie Young, March 1939.

How Would You Answer This?

The maternity forum this month is given over to a question from a nurse in Wyoming. An answer will be published in the May issue. In the meantime, won't you send in your suggested answer and also your questions on maternal welfare to Maternity Center Association, 654 Madison Avenue, New York, N. Y.?

I would like some advice on the following procedure:

I visit my antepartum patients and have them prepare the materials to be sterilized for the confinement. When a patient has no pressure cooker available, it is necessary for me to secure one from the county demonstration agent. I make a date to bring the county eighteen-quart pressure cooker to the patient's home and help her pack her materials in and sterilize them. In these cases it is my responsibility to stay with the pressure cooker until the sterilizing is finished, which takes at least an hour and a half. At this time I go over with the patient the handling of the sterilized material and the final preparation of her bedroom for the delivery. Since I am the only nurse in the county and doing a generalized program, I have wondered if this amount of time is justifiable? Of course all procedures are approved by the local physicians.

Since it is our aim to teach people to depend upon themselves, using their own resources when possible, would it be a better piece of public health nursing to teach those families who are unable to obtain a pressure cooker how to sterilize supplies in their ovens? The reason I resorted to using the county pressure cooker was that I soon learned they were not sterilizing their supplies, even though other methods were explained to them.

Do you consider sterilizing procedure to be important or would washing and airing the supplies and preparing them as stated in the *Manual of Public Health Nursing* be sufficient?

MAY BAILEY, R.N.
Evanston, Wyoming

Gleanings

Suggestions in regard to improvised equipment, methods of publicity, and new ideas that have proved practical are published in this column. Contributions are welcome.

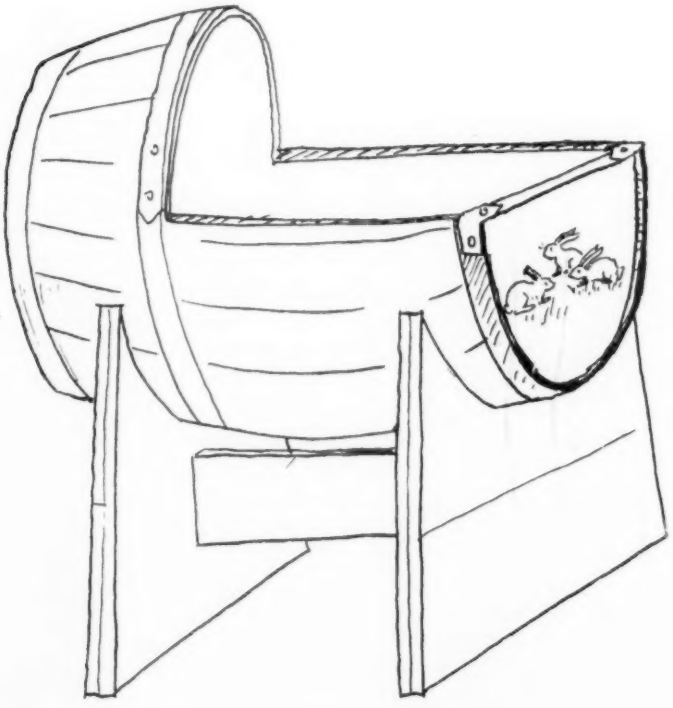
A BARREL FOR BABY

When the recreation department of our Works Progress Administration made a baby barrel for us, we did not realize the sensation it would cause. Several expectant fathers looked at it and two of them made beds. One mother recently stated that she could not get anything done because of the visitors who came to look at the bed; she had nineteen visitors one day and eleven the next.

It is a very inexpensive baby bed and most attractive. It is far more practical than one made from an orange crate because the baby can use it much longer. The total cost was:

Barrel	$ .25
Materials for base	.90
Paint	.75
Total cost	$1.90

Helen Wilson, R.N.
Public Health Nurse,
Warrick County, Boonville, Indiana



The Nurse's Part in the Control of Cancer

By LOUIS C. KRESS, M.D.

Every woman should know the symptoms which may signify early cancer in the breast or uterus and should realize the necessity for immediate and reliable medical care

Part III

WERE it not for cancer found in the breast and uterus, cancer would be a more prevalent disease in the male than in the female.

CANCER OF THE BREAST

Cancer of the breast takes a yearly toll of about 13,500 lives in the United States. It is therefore estimated that between 40,000 and 45,000 women and men have the disease at the present time. Men as well as women have cancer of the breast although this disease is more common among women. Anything in this article concerning the female breast also applies to the male breast.

Most women are unaware that a lump is present in their breasts because they do not know how to palpate (feel) these lumps or they do not visit a physician for an examination. Cancer of the breast as well as cancer found elsewhere in the body responds better to treatment if seen in its early stages. In early cancer of the breast when the disease is still confined to the breast about 70 percent to 80 percent of the patients receive a permanent cure, but after it leaves the breast and travels by means of the blood or lymph to other parts of the body, the number of cures falls to 20 percent. In young women thirty years of age suffering from early cancer of the breast, the results are the same as in the older age-group; but in cases where the cancer has spread to other parts of the body, only 7 percent of these young women are cured. Few women develop cancer of the breast before the age of thirty but when it does occur the results of treatment are not very good.

If women wish to discover lumps in the breast early, they must learn to palpate their own breasts and have regular examinations by their physicians for this purpose. These are the only two ways of discovering cancer of the breast early. The method of palpating the breasts is the same as that used by a physician. The breast should be pressed gently against the chest by the palm of the hand, never using the tips of the fingers. In this manner even the smallest lump can be felt in the breast.

The symptoms of early cancer of the breast are the lump, bleeding from the nipple, and ulceration or excoriation (cracking or peeling of skin) of the nipple or the areola (skin about the nipple). Later the patient may complain of retraction (drawing backward) of the skin over the lump, retraction of the nipple, swellings or nodes in the axilla (armpit) or the supraclavicular region (space over the collar bone), and pain. Cancer may also travel to the lungs causing difficulty in breathing and to the long bones, causing pain in the extremities and joints. The liver may also become enlarged. A woman should not wait for a lump to become painful;

this is one of the latest symptoms of cancer.

If a lump is discovered in the breast, should it cause unnecessary alarm? Not at all, because only 10 percent of the lumps discovered in a patient's breast are malignant. The other 90 percent are noncancerous and can be cured by simple excision. At the first appearance of a lump, regardless of its size, a person should seek an immediate examination by a practicing physician. It is not possible for a doctor to diagnose correctly every tumor in the breast by means of palpation and sight. Every lump in the breast should be considered cancer until proved otherwise. It must be removed and examined under the microscope before a definite diagnosis can be made.

Recently, a patient was referred to the writer for examination of a lump in her breast. She had been seen by two other surgeons and all three of us thought it was not a malignant growth. However, upon removal and microscopic examination it proved to be cancer—thus emphasizing the importance of determining accurately the character of a lump in the breast.

In studying a large group of patients who had been operated upon for cancer of the breast it was found that in every instance the lumps were discovered by the patients and not by their doctors, an evidence that people do not have periodic health examinations. Another sad fact disclosed by this survey was that after these women had discovered lumps in their breasts, they waited from two weeks to twenty-nine months before seeking medical advice.

Bleeding from the nipple is another symptom of cancer of the breast but it is also characteristic of duct papilloma, a noncancerous growth, and chronic mastitis. The latter is a disease of the breast associated with ovarian disfunction, usually manifesting itself by multiple thickened areas scattered throughout both breasts. Ulceration of the nipple or the surrounding skin appears as an open bleeding sore. This was formerly considered a forerunner of cancer but today it is treated as a true malignancy. Some growths in the breast are cystic and contain fluid. These are usually not cancerous but should be removed as they might become malignant.

All of the above symptoms necessitate a physical examination. Nurses who are consulted by women complaining of one or more of these conditions should refer them to a physician for prompt investigation.

TREATMENT

The treatment for early cancer of the breast is surgery, supplemented when necessary by x-ray. Most women object to the removal of a breast. Nurses who are familiar with cancer of the breast can often persuade such women to have their breasts removed as many women place confidence in the advice of a nurse.

The majority of people today if they develop a pain in the lower right abdomen associated with nausea and vomiting call in a physician at once, suspecting appendicitis. As soon as such a diagnosis is made, the first thought of the patient generally is, "When is he going to operate?" This response has been brought about through education, and people now know that surgery is the cure for appendicitis. If the women of the nation would take the same attitude regarding a lump in the breast as they do toward appendicitis, deaths from cancer of this organ would not be so numerous.

The breast is a specialized skin gland situated on the outside of the body. Its function is the manufacturing of milk. This gland is accustomed to outside infection and is able to withstand it. Therefore, surgery performed on the breast is not so dangerous as that associated with the removal of an appendix.

Few people would hesitate for a moment to have an appendix removed, yet the risk in a breast amputation is less dangerous as there is seldom an immediate death following a breast amputation.

X-ray treatments are sometimes given before or after the removal of a breast to prevent or forestall a recurrence of the cancer. Both methods are approved by surgeons and x-ray men everywhere and the question of which procedure should be followed is merely a matter of opinion.

When cancer has spread from the breast and axilla to other organs, surgery is not advocated except in the case of an infected or ulcerating breast, for hygienic reasons. Radiation in the form of radium or x-ray is the accepted form of treatment. Of course, more cures are obtained in early lesions of the breast, whereas the results obtained with cancer in the advanced stages are always problematical. Occasionally, unusual recoveries are achieved in patients having advanced cancer of the breast but this is not the general rule.

Nurses with an intelligent understanding of cancer of the breast should acquaint women with the importance of early diagnosis and treatment. They can be very helpful in encouraging the excision of a tumor or an amputation of a breast and in allaying fears regarding these operations.

CANCER OF THE UTERUS

A vaginal discharge does not usually worry the majority of women; yet it is a very significant symptom, the cause of which should always be investigated by a practicing physician. A vaginal discharge of any character is usually the result of an inflammation, irritation, or new growth. It may or may not be bloody. There are about ten different causes of irregular bleeding other than the regular menstrual flow. Cancer is one possible cause. Therefore, a woman having an abnormal discharge from the vagina should not become alarmed but should take an intelligent attitude toward this discharge and have a vaginal examination immediately. At times the cause of a vaginal discharge may be eradicated by a simple office procedure. At other times it requires a more extensive operation which must be performed in a hospital.

Cancer of the uterus is divided into two large groups—that found in the cervix or opening of the womb, and that found in the body or upper portion of the womb. Ninety percent of cancers of the uterus are found in the opening while only ten percent are found in the body or fundus of this organ. Malignancies of the cervix are usually found in younger women in the childbearing age, whereas cancer of the fundus develops in women who have stopped menstruating and have reached the so-called change of life period. It is erroneous for women to consider irregular vaginal bleeding as a natural indication of change of life. The menopause is a normal physiological change which in most instances does not cause women much physical discomfort. If any abnormal symptoms other than hot or cold flashes accompany the menopause, an examination by a competent physician is required.

There is no set group of symptoms which holds true for all patients suffering from cancer of the cervix. Probably the most common complaint is irregular bleeding which may be just a spotting between regular menstrual periods or may be hemorrhages. The spotting may follow insertion of a douche tip, or intercourse. The discharge may be brownish, bloody, white, yellowish, or watery. It may be tinged with blood, odorless, or foul-smelling. No woman should wait for pain to accompany a vaginal discharge. The only time cancer of the uterus becomes painful is when it leaves the uterus, extends into the pelvis, and encroaches upon the nerves found there.

Cancer of the cervix is often associated with childbearing. Delivery of a baby through the normal birth canal often results in injury to the cervix. However, if this injury is repaired, the cervix will return to its normal state. The time of repair is left to the discretion of the obstetrician who delivers the baby. Sometimes it is done immediately following delivery but some physicians prefer to do it at a later time. The laceration itself does not cause cancer but it is often combined with an inflammatory condition known as cervicitis. Cervicitis causes overactivity of both the superficial and deeper cervical glands which is evidenced by an irritating cervical discharge. This discharge by coming in contact with the ulcerating tissue of the tear will cause the tissues to set up a defense reaction in the form of a building-up process or hyperplasia. If this is allowed to go unheeded, it will develop into a cancerous growth.

If a nurse finds a woman who complains of a vaginal discharge, she should not disregard this condition but should urge the woman to visit a physician for a complete physical and vaginal examination. There are case histories on record of women who have had vaginal discharges for seven years; when they finally sought examination a cancer was found in the opening of the womb.

Cancer of the body of the uterus is usually associated with fibroid disease. The percentage of fibroid tumors which become malignant or undergo cancerous change is very small, but a woman having a fibroid tumor should not be satisfied with such a diagnosis until she has undergone a diagnostic curettage. This means the scraping of the body of the womb and microscopic examination of the tissue removed. Often a woman will believe that her irregular bleeding is caused by a fibroid tumor. Instead it may result from a small cancerous growth in the body of the uterus near the fibroid. It is impossible for a doctor to tell by manual examination alone whether this condition exists. He must resort to a curettage for an accurate diagnosis. No woman who has a vaginal discharge should hesitate to have a piece of tissue removed from the cervix or fundus of the uterus for microscopic examination.

A woman who has ceased to menstruate for a few months and who suddenly has profuse flowing should attend to this condition at once. Recently, a patient was examined who had not had any menstrual flow for thirty-one years and then suddenly had profuse bleeding from the vagina. Diagnostic curettage was done and it was found that she was suffering from cancer in the body of the uterus. This is the usual history of a profuse bloody or brownish discharge.

TREATMENT

The treatment of cancer of the cervix is a combination of x-ray and radium. If the malignancy is seen very early when it presents a nodular appearance and has not had an opportunity to ulcerate, surgery is indicated. Unfortunately, the medical profession sees very few early cancerous growths of this type in the cervix. The methods of treatment vary with the clinics in which they are given. The recognized treatment however is to subject a patient who is suffering from epithelioma or cancer of the cervix to external radiation in an endeavor to destroy as much of the local lesion as possible. After a suitable interval has elapsed the residual cancer is treated by interstitial, contact, or intracavitary radiation. The results in early cancer of the uterus are very gratifying. Cures are reported in from 67 to 70 percent of the cases treated but in the later stages of the disease the results are practically nil. Cancer of the body of the uterus is treated by surgery either preceded or followed by radiation.

The best method of obtaining better results in cancer of the uterus is to

make women familiar with the importance of a vaginal discharge. The nurse can play an important role in arranging public health talks on cancer as well as other diseases for various groups of women. Although nurses may not realize it, they have a great influence over women. Often people who are acquainted with nurses take their medical problems to them before they consult a physician. If nurses are familiar with the various phases of public health, they can guide their patients and acquaintances in the right direction.

Since the public health nurses in the State of New York have become familiar with the cancer problem, they have aided greatly in fostering the educational program. The cancer control program undoubtedly will be far more extensive in the future and the coöperation of the nurse will be more desirable than ever.

(Concluded)

QUALIFICATIONS OF NURSE IN ORTHOPEDIC PROGRAM

THE QUALIFICATIONS considered essential for public health nurses working in orthopedic programs are as follows:

1. Every public health nurse engaged in a crippled children's program:

a. Should have the minimum basic preparation in orthopedic nursing set forth in the new Curriculum Guide for Schools of Nursing.[1]

b. Should be a well qualified public health nurse according to the minimum requirements of the National Organization for Public Health Nursing.[2]

2. Public health nurses engaged in a supervisory or consultant capacity should have advanced preparation in orthopedic nursing. These consultants or supervisors should not function as physical-therapy technicians unless they have completed an approved physical-therapy course.[3]

These qualifications have been approved by the Crippled Children's Advisory Committee of the United States Children's Bureau and the Education Committee of the National Organization for Public Health Nursing.

The Committee on the Care of the Child of the National League of Nursing Education and the Council on Orthopedic Nursing of the National Organization for Public Health Nursing have agreed to work together on an outline for a unit of study and clinical experience in orthopedic nursing on an advanced level to prepare teachers and supervisors in hospitals and orthopedic consultants in the public health nursing field.

It is hoped that at least a progress report may be ready in time for presentation in April to the National League of Nursing Education at its annual meeting in New Orleans, Louisiana.

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[1] National League of Nursing Education. A Curriculum Guide for Schools of Nursing. National League of Nursing Education, 50 West 50 Street, New York, second revised edition, 1937.

[2] National Organization for Public Health Nursing. "Minimum Qualifications for Those Appointed to Positions in Public Health Nursing." PUBLIC HEALTH NURSING, March 1936. Reprints free.

[3] Council on Medical Education and Hospitals. "Approved Schools for Physical Therapy Technicians." *The Journal of the American Medical Association*, March 26, 1938, page 982.

First Meeting of Council of Branches

"The National Organization for Public Health Nursing for some time has been studying ways in which it can be made more democratic, can secure greater participation from all its members, and can be directed by thinking from the field as well as by the ideas of its board and staff. We now hope that in the Council of Branches, machinery for this democratic functioning has been found."

It was with these words that Grace Ross, president of the N.O.P.H.N., opened the first meeting of the newly formed Council of Branches which took place on January 24, at the Roosevelt Hotel in New York City.

During the meeting, Edna Hamilton, delegate from the Michigan S.O.P.H.N., was unanimously elected chairman of the Council for the coming year. Following is her report of the session, which was presented at the N.O.P.H.N. Board meeting of January 25.

January 24, 1939, should stand as a milestone in the history of our National Organization. On that day the N.O.P.H.N. had invited the presidents or other delegates of the 19 state organizations for public health nursing to meet together with the president and the staff of the organization for the purpose of organizing a Council of Branches.

An interesting handbook on the whys, wherefores, and purposes of the state organization for public health nursing had been prepared by Ruth Houlton and other staff members. Miss Houlton will be the N.O.P.H.N. secretary of the Council.

Some of the questions presented in this handbook and discussed by the group were:

1. How to obtain a budget.
2. Joint N.O.P.H.N. and S.O.P.H.N. dues.
3. How to secure active lay participation.
4. Plans for affiliation with other state health and welfare organizations.
5. Methods by which the committees in state branches may assist N.O.P.H.N. committees.

It was interesting to note that all of the states represented hold their annual meetings jointly with the state nurses' associations, and that many also hold additional meetings during the year with other allied groups.

In three southern and western states over 50 percent of the nurse membership was from the staff of the state health department.

Much discussion was caused by the question regarding the machinery to be set up for assisting state leagues of nursing education in the development of public health nursing as part of the basic school curriculum. It was agreed that the S.O.P.H.N. committee on education in each state should offer assistance to the state board of nurse registration in evaluating fields for student affiliation. In turn these state education committees will ally themselves closely with the Education Committee of the National Organization.

Evelyn K. Davis of the National suggested that a committee member from a school of nursing should be a member of each S.O.P.H.N. committee on education and that there should be lay member representation on all committees.

Other topics discussed at the meeting included:

1. The part of S.O.P.H.N.'s in relation to public health legislation within the state.
2. The responsibility of S.O.P.H.N.'s in connection with adoption of the merit system for selection of nurses for public health positions.
3. Ways in which the National Organization can best help the branches.

Marie Swanson, chairman of the N.O.P.H.N. Nursing Section, and Joanna Johnson, chairman of the Industrial

Nursing Section, spoke of the importance of including school and industrial nurses in S.O.P.H.N. membership and activities.

We hope this coming year will bring many more state nurses' associations and public health nurses to realize the importance of lay participation through an S.O.P.H.N. organization.

We wish to extend to the N.O.P.H.N. our appreciation not only of the opportunity now given us to work more closely together as members of the Council, but also for the closer relationship which we will have with our National Organization for Public Health Nursing through the Council of Branches.

The Council should prove very helpful to all existing S.O.P.H.N.'s as well as to those states which are considering such an organization. There is no doubt that an S.O.P.H.N. is most valuable because it may include as members everyone interested in public health nursing who wishes to belong. We know that lay participation and participation of all citizens and groups must be our goal in order to promote good public health nursing. A membership with full voting power permits real participation.

The Council of Branches wishes to thank the President and staff of the National Organization for the careful planning of our program of January 24 and for the delightful hour spent at the tea held in the British Empire Building after the day's sessions were over.

EDNA HAMILTON
Chairman

NURSE PLACEMENT SERVICE

N·P·S CHICAGO announces the following placements among appointments made in the various fields of public health nursing. As is our custom, consent to publish these has been secured in each case from both the nurse and the employer.

Dorothy Rood, Ph.D., Associate Professor and Director of Public Health Nursing, Loyola University Medical School, Chicago, Ill.

Katharine Huff, Supervising Public Health Nurse (Temporary), Department of Health, Conn.

Hattie Samples, Public Health Nurse of Demonstration Unit, Montgomery County Health Department, Rockville, Md.

Mary A. Hanley, Field Nurse, South Carolina Tuberculosis Association, Columbia, S. Car.

Alice B. Petersen, Community Nurse, Winchester District Nursing Association, Winchester, Mass.

Betty Churchill, Community Nurse, American Red Cross, Elizabethtown, N. Y.

Mrs. Violet Wells, Child Welfare Nurse, Amity Society, Freeport, Ill.

Genevieve Sonaglia, Itinerant Nurse, American Red Cross, Kans.

Anna Christensen, Orthopedic Nurse (Temporary), Division for Handicapped Children, Springfield, Ill.

Esther Hart and Marcella Earls, Staff Nurses, Department of Public Health Nursing, Greenwich, Conn.

Jane Cordes, E. Deborah Smith, and Ruby Brouillette, Staff Nurses, Visiting Nurse Association, Detroit, Mich.

Clarenda E. Brewer, Staff Nurse, City Health Department, Fargo, N. Dak.

Annette Sheehy, Staff Nurse, Judson Health Center, New York, N. Y.

Mildred Booth Henry, Staff Nurse, Department of Public Welfare, Division of Public Health, Boise, Idaho.

Mrs. Valta McGrath, School Nurse, Public Schools, Highland Park, Ill.

Assisted placement

Catherine Quigley, District Supervisor, Department of Health, Ky.

Interesting opportunities are available in various parts of the country. Already school positions are being listed for next autumn. Nurses interested in summer and fall appointment should register now.

Summer Courses for Public Health Nurses

SUMMER COURSE IN COLLEGES AND UNIVERSITIES WHOSE PUBLIC HEALTH NURSING CURRICULA HAVE BEEN APPROVED BY THE NATIONAL ORGANIZATION FOR PUBLIC HEALTH NURSING

For students meeting the admittance requirements, this work may usually be counted toward a degree.

California

Berkeley. University of California. Intersession, May 15-June 23. Summer Session, June 26-August 4. The following courses are to be conducted as an institute of 3-weeks' duration (June 26-July 14) for graduate nurses who are registered in the State of California: Nursing and Social Problems in the Control of Syphilis and Gonorrhea—Mrs. Evangeline H. Morris; Medical Problems in the Control of Syphilis and Gonorrhea—Dr. Malcolm H. Merrill and staff; Group Discussions—Ruth Hay and Margaret Blee. Nonresident graduate nurses who are registered in their respective states may be admitted upon consent of Ruth Hay. Other courses in Psychology, Sociology, Economics, Education, Child Development, and School Health will be offered during the regular intersession and summer session.

For further information write to Ruth Hay, Assistant Professor, Teaching Public Health Nursing.

District of Columbia

Washington. Catholic University of America. June 30-August 12. Courses in Teaching Principles in Public Health Nursing, Special Fields in Public Health Nursing, Public Health Administration and Nutrition. Other courses required in the public health nursing program in the following fields: Sociology, Social Case Work, Psychology, Public Speaking, and Child Study. Related courses in Economics, Philosophy including Ethics, and Political Science.

For further information write to Mary C. Connor, Director of Public Health Nursing, The School of Nursing Education.

Massachusetts

Boston. Simmons College. July 3-August 11. Courses in Anatomy and Physiology, Teaching in Schools of Nursing, Ward Management, Principles of Supervision, Principles of Teaching, Psychology for Nurses, Principles of Public Health Nursing, and Public Health Nursing in Schools.

For further information write to Director of the School of Nursing.

Michigan

Ann Arbor. University of Michigan. June 22-August 5. Courses in Principles, Administration, Organization, and Supervision of Public Health Nursing; Health Education, Child Hygiene, School Health Programs, Communicable Diseases and Epidemiology, Nutrition, Public Health Law and Administration, Public Health Statistics, Sanitation, Mental Hygiene, Psychology, Social Case Work, and Public Speaking.

For further information write to Hazel Herringshaw, Acting Director of Public Health Nursing.

Detroit. Wayne University. June 26-August 4. Courses in English, Sociology, and Psychology, which are required for public health nursing certificate.

For further information write to Louise Knapp, Director, Nursing Education Department.

Minnesota

Minneapolis. University of Minnesota. June 19-July 28. Courses in Elements of Preventive Medicine, Nursing and Social Problems in the Control of Gonorrhea and Syphilis, Tuberculosis and Its Control, Field Practice with Family Health Agency, and Public Health Administration—General, Special Methods, and Supervised Practice in Health Teaching. July 31-September 1. Courses in Health of the School Child, Tuberculosis and Its Control, Principles of Public Health Nursing.

For further information write to Margaret Arnstein, Director, Course in Public Health Nursing.

Missouri

St. Louis. St. Louis University. June 30-July 29 in School of Nursing, June 19-July 29 in other schools. Courses in Principles of Public Health Nursing, Nutrition, Biology, Mental Hygiene, Sociology, and Nursing Education.

For further information regarding courses in public health nursing write to A. Louise Kinney, Director, Public Health Nursing; for Nursing Education write to the Registrar, School of Nursing.

New York

New York. Teachers College, Columbia University. June 30-August 11. Courses in Principles, Teaching, Supervision, Nursing, Field Work in Public Health Nursing, School Nursing, Child Hygiene, and Public Health Administration. Courses are also available in such related fields as Education, Psychology, Sociology, Mental Hygiene, Guidance, Child Development, Parent Education, Nutrition, and Social Work.

For further information write to the Secretary of Teachers College.

New York. New York University. July 1 to 30. Courses in Principles of Public Health Nursing, Organization of School Nursing and Administration of Public Health, Psychology, Nutrition, Child Hygiene, Principles and Practices in First Aid, and Principles and Methods of Teaching in Home Nursing and in Nursing Education.

For further information write to Dr. Helen C. Manzer, Associate Professor of Education.

Ohio

Cleveland. Western Reserve University. June 19-July 29. Courses in Practical Sociology, Public Welfare, and Rural Communities.

For further information write to Lucy E. Massey, Associate Professor of Public Health Nursing.

Pennsylvania

Philadelphia. University of Pennsylvania. June 27-August 8. Courses in Fundamental Principles, Organization, Administration, and Special Phases of Public Health Nursing including Maternity, Infancy, Preschool, and School Nursing, and Social Case Work Approach to Problems of School Children. Also general academic courses in Education, Related Sciences, and Social Studies.

For further information write to Katharine Tucker, Director, Department of Nursing Education, Bennett Hall.

Pittsburgh. Duquesne University. June 29-August 11. Courses in Principles of Public Health Nursing, School Nursing, Sociology, Psychology, and related courses in Education. Field Practice in Public Health Nursing.

For further information write to Clara B. Rue, Director, Course in Public Health Nursing.

Tennessee

Nashville. George Peabody College for Teachers. June 12-August 25. Courses in Fundamental Principles, Administration, and Special Services in Public Health Nursing, Industrial Nursing, School Nursing Field Work, Infant and Child Hygiene, Preventive Medicine and Public Health Administration, Health and Food, Methods in Community Health Education, Sociology, Child Welfare, and Social Case Work.

For further information write to Aurelia B. Potts, Director, Department of Nursing Education.

Washington

Seattle. University of Washington. June 19-August 18. Courses in Special Fields in Public Health Nursing, Epidemiology, Rural Public Health Nursing, Methods of Teaching Nursing and Health, as well as Sociology, Psychology, Education, Social Work, Physiology, and Bacteriology.

For further information write to Mrs. Elizabeth S. Soule, Director, School of Nursing Education.

OTHER COURSES NOT A PART OF CURRICULA WHICH HAVE BEEN EVALUATED BY THE N.O.P.H.N.

American Red Cross teacher training courses for instructors in Home Hygiene and Care of the Sick, in coöperation with:

University of California, Los Angeles, California ..... June 26-August 4
Colorado State College, Fort Collins, Colorado ..... July 8-August 18
George Peabody College for Teachers, Nashville, Tennessee ..... June 12-August 12

Permission may be obtained for a nurse to register for six weeks only and to return to complete the work the following summer or during any quarter in which the course is offered.

For further information write to Public Health Nursing and Home Hygiene and Care of the Sick Service:

Nursing Service, National Headquarters, American Red Cross, Washington, D. C. (for Eastern Area); Midwestern Area, American Red Cross, 1709 Washington Avenue, St. Louis,

Missouri (for Midwestern Area); Pacific Area, American Red Cross, Civic Auditorium, San Francisco, California (for Pacific Area).

The National Society for the Prevention of Blindness sponsors sight-saving courses for the training of teachers and supervisors of sight-saving classes at:

University of California, Los Angeles, California ..... June 26-August 4
Wayne University, Detroit, Michigan ..... June 26-August 4
State Teachers College, Buffalo, New York ..... (dates tentative) June 26-August 4
Western Reserve University, Cleveland, Ohio ..... June 19-July 28
State Teachers College, Milwaukee, Wisconsin ..... June 26-August 4

For further information regarding the courses write to the university or college at which the courses are given.

Office of Indian Affairs, U. S. Department of Interior, Washington, D. C., sponsors courses at:

Oglala School, Pine Ridge Agency, South Dakota. June 5-30. Courses in Health Education, Mental Hygiene, Principles of Community Education. Lectures on Tuberculosis and Venereal Disease.

Wingate Vocational School, Fort Wingate, New Mexico. July 5-August 2. Courses in Health Education. Lectures on Tuberculosis and Venereal Disease. July 19-August 2. Conference for Indian Assistants on Red Cross First Aid, and Trachoma Control.

For further information write to the Office of Indian Affairs.

California

Los Angeles. University of California. June 26-August 4. Courses in Principles of Public Health Nursing, Public Health and Preventive Medicine, and Social Case Work as Related to Public Health Nursing. Courses also in Education, Sociology, Psychology, Mental Hygiene, Child Development, and School Health.

For further information write to Dean of the Summer Session.

Colorado

Greeley. Colorado State College of Education. Two four-week sessions: June 19-July 14; July 17-August 11. Courses in Health Organization and Administration, School Health Education, Guidance in Nursing Education. General courses in Psychology, Sociology, Nutrition, and Education.

For further information write to Department of Publications.

Illinois

Chicago. University of Chicago. June 21-July 21, first term; July 24-August 25, second term. Courses in Principles, Special Fields, and Supervision in Public Health Nursing, and in the Teaching of Health. Other courses in related fields.

For further information write to Nellie X. Hawkinson, Nursing Education.

Indiana

Bloomington. Indiana University. June 13-August 9. Courses in Principles of Public Health Nursing, Supervised Teaching in Health, Practice in School Nursing. Courses in Education, Psychology, and Sociology.

For further information write to H. L. Smith, Director of the Summer Session.

Kentucky

Lexington. University of Kentucky. June 12-July 15, first term; July 17-August 19, second term. Courses in Public Health, Maternal and Child Health, Vital Statistics, Mental Hygiene, Public Health Nursing, County Health Practice, Social Work Information, and Elementary Psychology.

For further information write to Elma Rood, Department of Hygiene and Health.

Massachusetts

Boston. Harvard University. June 19-August 4. A course in Physiotherapy open to graduate nurses.

For further information write to the Assistant Dean, Courses for Graduates, Harvard Medical School.

New York

Buffalo. The University of Buffalo. July 5-August 12. Courses in Principles and Field Work in Public Health Nursing, including School Nursing, Mental Hygiene, Case Work Methods, and Orthopedics.

For further information write to Anne Sengbusch, Educational Adviser to Nurses.

Ithaca. Cornell University. July 3-August 11. Courses in the School Health Program, Mental and Physical Problems of the School Child, and Mental Hygiene.

For further information write to the Director of the Summer Session.

(Continued on page 250)

NOTES *from the* NATIONAL ORGANIZATION FOR PUBLIC HEALTH NURSING

HISTORY IN THE MAKING

If you were conscious during the week of January 23 of a slight tilt of our continent toward the East Coast, it was because there was such heavy thinking going on among public health nurses who had come from the west, midwest, and south to join the eastern group for the annual meetings of the boards and committees of the three national nursing organizations.

The N.O.P.H.N. alone welcomed representatives from nine states west of the Mississippi River, and all but one of our branches sent a delegate to the first eventful meeting of the newly formed Council of Branches. (See page 234 for its special report.) Twenty-five of our thirty-one board members were present in spite of the prevalence of flu which was bearing down on visitors and residents alike. In all, about one hundred people participated in our week of meetings, including members of our Advisory Council and the chairmen of the three N.O.P.H.N. sections.

Much was accomplished in our board meeting besides the usual business of an annual meeting. (See the March issue, page 179, for the 1938 financial report of the Organization.) The most important business was the acceptance of the statement which the N.O.P.H.N. presented to the Interdepartmental Committee to Coördinate Health and Welfare Activities in Washington. This statement, which is printed on page 133 of the March magazine, embodies the Organization's opinion on how public health nursing fits into the National Health Program.

Among the many decisions made by the Board, a few which are of special interest are summarized here:

It was agreed that a very important future step is to make it financially possible for the N.O.P.H.N. to add an industrial nurse consultant to the staff.

It was suggested that plans be made next year for a joint meeting of the N.O.P.H.N. Council on Maternity and Child Health and the Committee on the Care of the Child of the National League of Nursing Education.

It was voted to accept the invitation of the American Public Health Association to meet with the Association in Pittsburgh, Pa., October 17-20 at the time of its sixty-eighth annual meeting.

It was voted not to participate as a separate organization in an exhibit at the World's Fair.

It was voted to circularize again the member agencies of the N.O.P.H.N. to find out how boards of directors regard the inclusion of non-profit-making agencies under the clauses of the Social Security Act.

The Board voted to give the Eligibility Committee authority to set up agency membership qualifications and to submit these at a future meeting of the Board with a view to revising our by-laws on this point.

It was voted to approve the recommendation of the Joint Committee on Community Nursing Service that it be given freedom to search for funds outside of the three national nursing organizations for support of its work.

Appropriate resolutions on the death of Ella Phillips Crandall, the first executive secretary of the N.O.P.H.N., were passed by the Board, spread upon the minutes, and sent to the members of her family.

Among the activities of the committee

meetings, the report of the Publications Committee stands out as a most encouraging one. The magazine has a lower deficit and a higher list of subscribers than ever before. (For its financial statement see the March magazine, page 179.)

Another committee report of interest to all was the first report of the new Advisory Committee on Vocational Counseling of which Alma C. Haupt is chairman. Miss Haupt reported that the Committee had given tentative approval to the Nursing Bureau of Manhattan and Bronx for placement service to public health nurses. Final approval is awaiting the development of the service under the new public health nurse placement secretary and the study of the service by the N.O.P.H.N.

The meeting of the three boards of the national nursing organizations, which is known as the "Joint Board Meeting," was held on January 26, 1939, and was well attended by the members of all three boards. Reports from the joint committees were read and accepted, those of special interest being that of the Joint Committee on Subsidiary Workers and that of the Joint Committee on Community Nursing Service. The three national nursing organizations also adopted a resolution to be sent to the Interdepartmental Committee to Coördinate Health and Welfare Activities in Washington. These have appeared in full in *The American Journal of Nursing* for March, page 233. The joint boards also discussed at length, machinery for a more smoothly working plan of joint action when national emergencies arise requiring the immediate action of all three national nursing organizations. During the morning Dr. Clifford Waller of the United States Public Health Service explained to the boards the plan of the National Health Program and answered questions from our various members.

Throughout all the meetings we had the great pleasure of having with us Anna Schwarzenburg, Executive Secretary of the International Council of Nurses, who was here to make preliminary plans for the International Congress of Nurses which will be held in the United States in 1941. A dinner in honor of Miss Schwarzenburg was held by the three national nursing organizations on January 24 and at this same dinner the Warner Brothers presented the National League of Nursing Education with the films, "The White Angel," and the "Life of Louis Pasteur." On Wednesday evening, January 25, the Advisory Council, the Board of Directors, chairmen of Sections, the delegates to the Council of Branches, and the N.O.P.H.N. staff met at dinner in the Women's City Club and enjoyed an informal discussion and address by Dr. Michael M. Davis on the place of a national voluntary agency in a democracy. (See page 192.) The apt, humorous, but always thoughtful comments made by Dr. Davis on public health nursing progress and the relationship of the National Organization to the whole movement were greatly enjoyed by the fifty people who attended the dinner.

WITH THE STAFF

Two members of the staff went on extensive field trips during March. Evelyn Davis went to Canton, Ohio, on March 22 to participate in a board members' discussion meeting under the auspices of the Visiting Nurse Society. She spent March 23 and 24 in Cleveland, Ohio, speaking on lay committees to the students at Western Reserve University. She was in Michigan from March 27-30, studying the lay committee organization of the Children's Fund in Detroit and

the W. K. Kellogg Foundation in Battle Creek. She went to Des Moines, Iowa, on the 31st, to conduct a board members' institute under the auspices of the Public Health Nursing Association.

Ella McNeil spent March 2 in St. Louis, Mo., meeting with the Municipal Visiting Nurses. She went to Denver, Colo., on March 5 to attend the meeting of the State Nurses' Association at which time she conducted an institute on school nursing and took part in a panel discussion. She stayed in Santa Fe, N. Mex., from March 9-13, holding conferences with the state advisory nurses. She conducted a series of school nursing institutes in Arizona under the State Board of Health from March 16-22 in Flagstaff, Phoenix, Globe, and Tucson. March 23 and 24 were spent with the Visiting Nurses of San Diego, Calif. She again conducted a school nursing institute on March 27 and 28 under the auspices of the State Board of Health in Las Vegas, Nev. The last two days in March were spent in Los Angeles, Calif., holding conferences regarding visiting nursing service.

HONOR ROLL

All public health nursing agencies, including one-nurse services, are eligible for the N.O.P.H.N. Honor Roll. As soon as an agency sends word to the N.O.P.H.N. that all nurses on the staff are 1939 members, an Honor Roll Certificate will be sent and the name of the nursing service will be published in PUBLIC HEALTH NURSING. The name will appear only once, as the list published shows only those nursing services which have achieved 100 percent enrollment since the publication of the previous list.

. . .

The list of agencies achieving 100 percent enrollment swells with every mail. We extend our sincere appreciation to all of the nurses whose memberships have made the following nursing services eligible for listing. The names of the agencies who have been on the Honor Roll list for five years or more are indicated with a star; those less than five years are not starred.

ALABAMA
- Limestone County Department of Public Health, Athens
- Franklin County Health Department, Russellville

CONNECTICUT
- Visiting Nurse Association, Bridgeport
- North Canaan Visiting Nurse Association, Canaan

ILLINOIS
- Bellwood Welfare and Health Organization, Bellwood
- Bellwood Public Schools Nursing Service, Bellwood
- Metropolitan Life Insurance Nursing Service, Bloomington
- Geneseo Public Schools Nursing Service, Geneseo
- Adams County Anti-Tuberculosis League, Quincy

INDIANA
- *American Red Cross Public Health Nursing Service, Fort Wayne
- Metropolitan Life Insurance Nursing Service, New Albany

IOWA
- *Public Health Nursing Association, Cedar Rapids
- Visiting Nursing Association, Waterloo
- American Red Cross, Clinton County Chapter, Public Health Nursing Service, Clinton

KANSAS
- Wyandotte County Physician and Health Officer Office, Kansas City

KENTUCKY
- Metropolitan Life Insurance Nursing Service, Frankfort
- Anderson County Health Department, Lawrenceburg
- Public Health Nursing Association, Louisville
- Wayne County Health Department, Monticello

LOUISIANA
- Metropolitan Life Insurance Nursing Service, New Orleans

MASSACHUSETTS
- *Visiting Nurse Association, Great Barrington

*Franklin County Public Health Association, Greenfield
*District Nursing Association of Barnstable, Yarmouth, and Dennis, Hyannis
Northampton Visiting Nursing Association, Northampton
Sandwich Health Association, Sandwich

MICHIGAN
Public Health Nursing Association, Ann Arbor
*Kent County Health Department, Grand Rapids
Metropolitan Life Insurance Nursing Service, Manistee
Ingham County Health Department, Mason
Metropolitan Life Insurance Nursing Service, Muskegon

MISSOURI
Metropolitan Life Insurance Nursing Service, Sedalia
Metropolitan Life Insurance Nursing Service, Springfield

NEW HAMPSHIRE
*Good Cheer Society, Nashua

NEW JERSEY
Central Bergen Visiting Nurse Service, Hackensack
*Montclair Bureau of Public Health Nursing, Montclair
*Metropolitan Life Insurance Nursing Service, Trenton

NEW YORK
Metropolitan Life Insurance Nursing Service, Glens Falls
Metropolitan Life Insurance Nursing Service of Nassau County, Hempstead
Hornell Public Schools Nursing Service, Hornell
Metropolitan Life Insurance Nursing Service, Malone
Mulberry Health Center, Association for Improving the Condition of the Poor, New York
Metropolitan Life Insurance Nursing Service, Port Jervis

NORTH CAROLINA
Orange-Person-Chatham District Health Department, Chapel Hill
Metropolitan Life Insurance Nursing Service, Gastonia
Martin County Health Department, Williamston

OHIO
*Metropolitan Life Insurance Nursing Service, Cincinnati
*Western Reserve University Public Health Nursing District, Cleveland
Division of Public Health Nursing, State Department of Health, Columbus
Metropolitan Life Insurance Nursing Service, Springfield

OKLAHOMA
*Public Health Association, Inc., Tulsa

PENNSYLVANIA
Visiting Nurse Society of Philadelphia, Manayunk Branch, Philadelphia
Pottstown Public Schools Nursing Service, Pottstown
Visiting Nurse Society of Pottstown, Sanatoga

RHODE ISLAND
North Providence School Nursing Service, Lymonsville
Nursing Service of School Department, Lincoln
Bureau of Child Hygiene, State Department of Public Health, Providence
*Providence District Nursing Association, Providence
*Woonsocket Public Health Nursing Association, Woonsocket

SOUTH CAROLINA
Edgefield County Health Department, Edgefield

TENNESSEE
*Metropolitan Life Insurance Nursing Service, Memphis
Shelby County Health Department, Nursing Division, Memphis

TEXAS
Taylor County Tuberculosis Association, Abilene
*Dallas School Health Department, Dallas
*Department of Public Health and Welfare, Fort Worth
Carson County Health Department, Panhandle

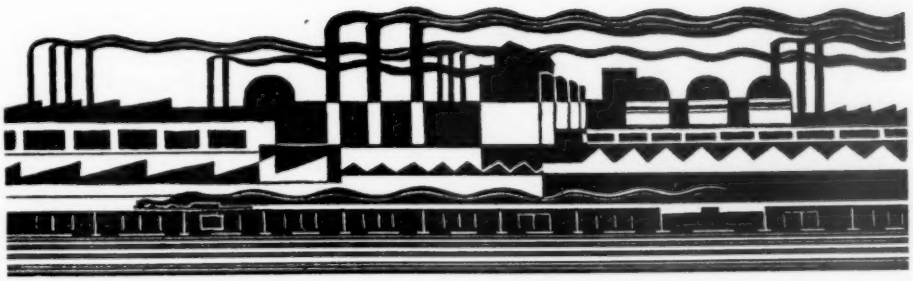
VERMONT
*Brattleboro Mutual Aid Association, Brattleboro

WASHINGTON
*Visiting Nurse Service, Seattle

WISCONSIN
*Visiting Nurse Association, Neenah
Metropolitan Life Insurance Nursing Service, Wisconsin Rapids

WYOMING
Platte County Health Department, Wheatland

HAWAII
*Palama Settlement, Honolulu



SUPERVISION OF INDUSTRIAL NURSING

WHO SHOULD SUPERVISE the industrial nurse's activities? This question was raised at the industrial nursing session of the National Safety Congress in Chicago, Illinois, October 13. (See December 1938 issue, page 730.)

The discussion of the question from the floor by Dr. C. O. Sappington, a specialist in the industrial health field, is published below.

The viewpoint of an industrial nurse is presented by Ruth C. Waterbury of the Metropolitan Life Insurance Company who through her long experience in group insurance work knows what nursing supervision and help mean to the nurse.

Some possible types of consultant service for helping the industrial nurse with her problems are suggested by Ruth Houlton of the N.O.P.H.N.

THE PHYSICIAN GIVES MEDICAL SUPERVISION

The obvious answer to this question is the physician, because physicians and nurses have always worked together and have an understanding of each other's aims and objectives.

For the moment, let us consider whether there are other persons who might be capable of supervising the nurse's activities in industry. Certainly it would not be the personnel manager, for he has not had the medical training and does not possess the viewpoint which is necessary for successful supervision; certainly not the safety man, for he probably has less training in personnel relationships and certainly is not trained either medically or in any other capacity which would make him an efficient supervisor for this particular work; certainly not the plant manager, for he is engaged in other activities and has such broad general interests that he would not, I believe, be interested in assuming the responsibility of directing the nurse's activities.

So we are right back where we started. The physician is the person who is capable of properly supervising the industrial nurse's activities because of the very nature of his training and experience.

C. O. SAPPINGTON, M.D., Dr.P.H.
Consulting Industrial Hygienist, Chicago, Illinois

SUPERVISION OFFERS PROBLEMS

If the question implies supervision in its usual literal meaning, the answer will vary with the type of industrial establishment, for the following reasons:

1. Only a very large industrial establishment, either mercantile or manufacturing, employing from 5000 to 10,000 or more workers, has a medical department under a full-time medical director and a staff of nurses with a supervising nurse in charge of the staff.

2. The largest percentage of industrial nurses

is to be found working alone in establishments employing from 300 to 2000 or more workers, with only part-time physicians in attendance or physicians on call for emergencies.

With respect to the first group, there is no argument as to who should supervise the nurses' work. The head nurse, or nurse supervisor as she is usually called, supervises the staff nurses' activities. The nurse supervisor in turn is directly responsible to the medical director, who is naturally a member of the executive management of the industrial establishment.

It is the second group—the great percentage of industrial nurses practically working alone—which offers problems in the adequate solution of this question. The visiting physician can direct the nurse's activities insofar as the care and treatment of emergency injuries and illnesses are concerned, by giving his written orders controlling such activities. However, the nurse is literally on her own except for the few hours each month when the physician is in attendance.

Observation in several hundred industrial establishments over a period of years bears out the fact that the nurse working alone with a part-time physician in attendance or a physician only on call for emergencies is more or less directly responsible to the personnel director, employment manager, or plant superintendent rather than to the visiting physician, for most of her activities. When an industrial management employs a nurse, it is assumed that her professional qualifications are adequate for the type of work she is to perform. While a certain part of her activities may come under the supervision of the personnel director or employment manager, neither is in a position to supervise her professional duties. And the very nature of her work, in addition to the fact that she is employed by a private organization, precludes outside professional supervision of her nursing activities.

Industrial nurses should realize the need for growth in the field of industrial health and should look to the National Organization for Public Health Nursing and their local industrial nurses' clubs to stimulate creativeness by group discussions and by instructive lectures from authorities on pertinent subjects.

RUTH C. WATERBURY, R.N.
Group Nursing Assistant, Metropolitan Life Insurance Company

THE NURSE CONSULTANT

Every public health nurse working alone, no matter how well qualified, needs help with her nursing problems from time to time. The industrial nurse is no exception, as evidenced by the fact that the National Organization for Public Health Nursing receives many requests for such help. The value to industry of a nursing consultant service is shown by the use which is made of the consultant service offered by some insurance companies to industrial plants which are policyholders. Universally plants have found this service to be helpful.

In the future, state departments of health may well offer a consultant service to industrial nurses, just as they increasingly give leadership in all other health activities within the state. Consultant help on a national basis might come from industrial nurses on the staff of the United States Public Health Service or the N.O.P.H.N. or both. As yet no state or national agency has offered this sort of help but leaders in industrial nursing are working toward this end.

RUTH HOULTON, R.N.
Associate Director, National Organization for Public Health Nursing

See page 201, "Safety in Home, School, and Industry," by Dr. W. Webber Kelly.

EDITED BY
ELLA E. McNEIL

HEALTH HYGIENE AND HOOEY

By W. W. Bauer, M.D. 322 pp. Bobbs-Merrill, New York, 1938. $2.50.

Dr. Bauer has written a book which gives a vast amount of accurate information on a wide variety of health subjects, but he has succeeded in putting it up in a form which can be read and really enjoyed by nontechnical people.

His name and position are assurance that the book is authentic and we feel that we can conscientiously recommend it to the general reader. It should go a long way toward debunking the vast amount of spurious health fare which is being fed to the public and should serve as a rather formidable opponent of quackery.

THURMAN B. RICE, M.D.
Indianapolis, Indiana

HEALTH INSURANCE WITH MEDICAL CARE

By Douglass W. Orr, M.D., and Jean W. Orr. 241pp. The Macmillan Company, New York, 1938. $2.50.

Those who have followed in the *Survey Graphic* the English adventures of Dr. and Mrs. Orr among the insured population will be glad to have their story, rearranged and largely rewritten, in a convenient book. Those who have not read their story before should be all the more eager to do so now. The Orrs not only give an objective account of what doctors and patients think about the National Health Insurance Act after twenty-five years of experience but they also explain how this particular legislation is related to the system of medical care out of which it grew and to the co-existing legislation for the provision of care to the indigent and to those who are sick from chronic communicable diseases. The share which the voluntary hospitals and the Queen's nurses take is explained and will be of particular interest to readers of this magazine. The authors conclude that in the United States we must "work out our own solutions in our own way." They are right also in thinking that "the example of Great Britain can contribute to our understanding both of principles and of methods."

J. ROSSLYN EARP, M.D.
Albany, New York

EAT AND KEEP FIT

By Jacob Buckstein, M.D. 128 pp. Emerson Books, New York, 1938. $1.

Books on diet appear from so many pens these days that it is sometimes hard to believe there could be sufficient demand to support new ones. However, any volume which presents in simple fashion the essentials of nutrition as modern science has defined them and gives advice on diet from a sane and well balanced point of view will always be welcome. Such is this small book, written by a specialist in the field of diseases of the digestive tract.

The fundamental concepts of metabolism, and the structure, use, and source of proteins, carbohydrates, fats, minerals, and vitamins are summarized accurately and in language which could readily be understood by the high-school student who has had a few elementary science lessons. The author has made sporadic attempts to humanize his subject with short quotations from poets, descriptions of food customs of primi-

tive man, or references to investigators who have discovered some of the principles he is expounding. But in the main, these are so loosely woven into the matrix of his story that they seem to detract more than they add to the clarity of the exposition. It does not seem either that the lay reader, for whom the book is probably intended, will often be interested in some of the details included.

The chapters on food fads and warnings against dangerous methods of weight reduction are well presented. An appendix includes charts presenting food values of common foods. This volume seems to answer the need of the public health nurse who desires a simple reference book which contains information which she will wish to teach adults or high-school students about nutrition.

LEONA BAUMGARTNER, M.D.
New York, New York

FIT TO TEACH

The Ninth Yearbook of the Department of Classroom Teachers

By National Education Association, 1201 Sixteenth Street, N. W., Washington, D. C., 1938. 276 pp. $1.

Since health appeared first on the list of the seven cardinal principles of secondary education in a bulletin published by the United States Office of Education in 1918, it is highly fitting that the Department of Classroom Teachers should dedicate its ninth yearbook to the health of the teacher.

The yearbook considers not only the physical health of teachers but includes their emotional and spiritual health.

Material for the yearbook has been based on previous studies and on questionnaires sent to teachers, principals, superintendents, and a limited number of physicians. Perhaps too much weight is given to the teacher's opinion regarding her own health rather than to findings based on medical examinations.

Such topics as the following are discussed: the health practices of the teacher, the school environment, home influences, and community services and responsibilities in relation to the health of the teacher. Definite recommendations are made regarding each topic. The yearbook also contains an excellent discussion of the responsibility of teacher-training institutions for the health of prospective teachers from the standpoint of selection of students and improvement of health during their training.

Fit to Teach is a very readable and valuable book and should make teachers more aware of the very close relationship between health and personality and effective teaching.

VERA H. BROOKS, R.N.
Newark, New Jersey

PSYCHOLOGY APPLIED TO NURSING

By Lawrence Augustus Averill and Florence C. Kempf. 471 pp. W. B. Saunders Company, Philadelphia, 1938. $2.50.

This is a textbook on psychology adapted especially for use in schools of nursing. The three chapters on psychology of childhood, adolescence, and the family are of special interest to public health nurses. The last chapter, on "The Nurse as Practical Psychologist," discusses the teaching function of the nurse in various hospital and clinic situations, in the home, and in the school.

P. P.

SOUTH ITALIAN FOLKWAYS IN EUROPE AND AMERICA

By Phyllis H. Williams. 216 pp. Yale University Press, New Haven, 1938. $2.50.

The author of this volume is a research assistant in sociology at the Institute of Human Relations, Yale University. This handbook is based on research projects but presents cultural rather than statistical or scientific data.

It is rightly termed a handbook in that it supplies a background for understanding the problems in adjustment which the South Italian and his children are still facing in this country. However, there are none of the limitations

which the term handbook might imply and an entirely enjoyable volume awaits one who has long pondered over the behavior patterns of certain Italian families.

The book contains enlightening chapters on housing, employment, diet, marriage and the family, religion and superstition, and health and the hospital, to cite a few of the subjects most pertinent to public health nursing. Each of these is considered from the point of view of practices as they were carried on in Italy at the height of the period of immigration to America and each is followed by a discussion of the social adjustment which has been necessary in this country.

The author ably succeeds in visualizing for the reader the reasons for the origin of Italian customs and for their persistence in this country long after the occasion which gave them birth has disappeared. This most interesting book is almost a prerequisite for those working with Italians. It is hoped that it will be followed by handbooks discussing the problems, customs, and mores of similar groups.

HELEN W. GOULD, R.N.
Greenwich, Connecticut

COPIES OF GOLDMARK REPORT

Libraries that have no copy of the *Report of the Committee on Nursing and Nursing Education in the United States*, by Josephine Goldmark (published by the Macmillan Company in 1925) may write to the Division of Nursing Education, Teachers College, Columbia University, New York, N. Y., for a copy.

Copies of this publication have been put at the disposition of the faculty for distribution—not for sale. Since this report is of historical interest as well as practical value, it seems best to have the copies placed where they can be accessible to student nurses and to groups of graduate nurses. In writing, please enclose twenty-five cents in stamps for wrapping and postage.

SOCIAL SERVICE EXCHANGE

Recommendations on Use of Social Service Exchange by Public Health Nursing Services is a series of studies on the use of the social service exchange by various types of social agencies. Copies are available at 15 cents each from the Welfare Council of New York City, 44 East 23 Street, New York, N. Y.

RECENT PUBLICATIONS AND CURRENT PERIODICALS

MENTAL HYGIENE

FOR NEW PARENTS. Agnes Tilson Adcock. *The Farmer's Wife Magazine*, Department of Child Welfare, St. Paul, Minn., 1937, 62pp. 25c.

A booklet on child training.

PARENT EDUCATION. Florence Brown Sherbon, M.D. *The Medical Woman's Journal*, November 1937, p. 318.

Includes a brief resumé of parent education activities of various agencies and a list of sources for information on this subject.

THE TROUBLED MIND—A STUDY OF NERVOUS AND MENTAL ILLNESSES. C. S. Bluemel, M.D. Williams and Wilkins, Baltimore, 1938. 520pp. $3.50.

GUIDING HUMAN MISFITS: A PRACTICAL APPLICATION OF INDIVIDUAL PSYCHOLOGY. Alexandra Adler, M.D. The Macmillan Company, New York, 1938. 88pp. $1.75.

A series of case studies showing the effect of an individual's actual or fancied inferiority on his behavior.

WOMAN'S PRIME OF LIFE—MAKING THE MOST OF MATURITY. Isabel Emslie Hutton, M.D. Emerson Books, Inc., New York, 1937. 148pp. $2.

A constructive discussion which does much to dispel the common fears and superstitions about this period of life.

NUTRITION

TABLES OF CONTENTS OF SCRAPBOOKS ON FAMILY BUDGETS, RELIEF STANDARDS, AND NUTRITION FOR WORKERS IN HEALTH AND WELFARE AGENCIES. The Social Welfare and Public Health Department, American Home Economics Association, Washington, D. C., June 1938. 16pp., mimeographed. May be obtained from M. M. Heseltine, 7135, U. S. Department of Labor, Washington, D. C., 15c., plus 5c. mailing charge.

A list of materials suitable for those working with low income families.

• The nurses of America, their responsibilities and compensations, will be discussed by Lum and Abner, noted radio team, on their coast-to-coast program during the week of April 10.

Nurses both in hospitals and in public health will not want to miss the special broadcast, arranged with the coöperation of the Nursing Information Bureau, 50 West 50 Street, New York, N.Y. Lum and Abner are expected to go into the subject, "Why Be a Nurse?" and pay a tribute to the loyalty and unselfishness of the nursing profession.

Their program is broadcast over the Columbia Broadcasting System each Monday, Wednesday, and Friday night at 7:15 Eastern, 6:15 Central, 9:15 Rocky Mountain, and 8:15 Pacific Coast time. Don't miss it! If you like it, write to the Columbia Broadcasting System, 485 Madison Avenue, New York, N. Y.

• "The health of the child is the power of the nation" is the slogan for Child Health Day on May 1, sponsored by the U. S. Children's Bureau at the request of the State and Provincial Health Authorities of North America in accordance with the Congressional Resolution on May 18, 1928, which authorized the President to proclaim this day. Its objectives are to bring to the attention of each community: (1) the importance to the child's health, development, and well-being throughout life of proper food, rest, exercise, medical care, and protection against disease (2) the ways of informing parents and others how child health may be safeguarded (3) the means whereby such safeguards may be made available to all children.

For state programs write to the May Day chairman of your state department of health.

• A full-tuition scholarship in health education is offered again this year to a public health nurse, by the Massachusetts Institute of Technology at Cambridge, Mass. This scholarship of $600 covers the cost of tuition for the scholastic year, beginning in September 1939 and closing in June 1940.

The scholarship will be awarded to a candidate recommended by the National Organization for Public Health Nursing. The award will be based upon the nature and quality of the previous academic work of the applicant, the ability which she has already shown in professional work in the field of public health, her need of scholarship aid, and the probable value of her further contribution to health education. Consideration will be given only to those candidates who possess a bachelor's degree. Those possessing a degree may count their work at the Institute toward a Certificate in Public Health.

The scholarship will be awarded in June 1939 and applications should be received not later than May 1. All those who are interested in this scholarship are invited to write to the National Organization for Public Health Nursing, 50 West 50 Street, New York, N. Y., for application blanks.

A similar scholarship is available to teachers through the National Tuberculosis Association, 50 West 50 Street, New York, N. Y.

• The Isabel Hampton Robb Memorial Fund Committee offers seven scholarships of $300 each to the seven applicants who stand highest in the competition closing May 1. The scholarships

are to be used during the academic year of 1939-40, and are for nursing courses. Application blanks and information may be obtained from the secretary of the committee, Mrs. Mary C. Eden, The Fairfax, 43 and Locust Streets, Philadelphia, Pa. Applications should be filed not later than April 20.

• The Advisory Committee on Vocational Counseling of the National Organization for Public Health Nursing, at its last meeting on January 23, gave tentative approval to the Nursing Bureau of Manhattan and Bronx, New York City, as a counseling and placement service for public health nurses. Full approval is dependent on a study of the Bureau's new public health nursing placement service. Letha Allen, who has been director of the Public Health Nursing Organization of Eastchester, Tuckahoe, N. Y., became placement secretary for public health nursing in the Bureau on April 1.

The Bureau has conducted a vocational and placement service in the private duty and institutional nursing fields since 1933. The service to public health nurses and organizations is now added because a need for it was created when the public health nursing service rendered by the Joint Vocational Service was given up.

• The fortieth anniversary of the Nursing Education Division of Teachers College, Columbia University, and the fiftieth anniversary of Teachers College will be celebrated this fall early in October, the exact dates to be announced later. A committee of representative nursing education alumnæ has been appointed and plans are now being made for the meetings in New York and for branch meetings to be arranged on the same date by alumnæ groups in different sections of the country. In order to have a correct list of addresses, former students who have changed their permanent address since they left the college are asked to send a post card to the Nursing Education office as soon as possible stating where individual communications may be sent.

• The first statewide conference sponsored by the National Council for Mothers and Babies was held in Raleigh, N. C., on February 15, in coöperation with the State Board of Health.

• In January, Winifred L. Fitzpatrick completed thirty-five years of service with the Providence (R. I.) District Nursing Association. She was presented with a scroll memorializing her services. Miss Fitzpatrick started as a staff nurse in the Association, then became supervisor, associate director, and finally director. She reported that "the year 1938 will probably be recorded in the history [of the association] as the healthiest year on record to date. There were 828 fewer patients cared for in 1938 than in 1937 because of a decrease in acute illness. While the hurricane handicapped the nurses to some extent through crippling of facilities, they carried on as usual."

• The New England Health Education Institute will be held at the Massachusetts Institute of Technology, Cambridge, Mass., on April 21 and 22. The program is under the direction of Professor C. E. Turner of the Department of Biology and Public Health.

• "The citizen's responsibility for community health" will be the objective of the National Negro Health Week, April 2 to 9. Free copies of the Health Week Bulletin, poster, and school leaflet may be obtained from the National Negro Health Week Committee, U. S. Public Health Service, Washington, D. C.

• The National Society for the Prevention of Blindness has announced that Lewis H. Carris, formerly managing director, assumed the title of general director on January 1, with Mrs. Wini-

fred Hathaway as associate director. Mrs. Eleanor Brown Merrill, an associate director for the past five years and formerly secretary of the Society, became executive director, relieving Mr. Carris of administrative details. John M. Glenn, one of the founders of the Society, has been elected an honorary vice-president.

• There are at the present time two study outlines prepared for board members available from the National Organization for Public Health Nursing.

One is the recently revised outline for self-survey of public health nursing programs. This sells for 25 cents and is a guide for the board and staff in studying their own program and other public health nursing services in the community.

The other outline has been available for some time and is for the local education committee to use in preparing a handbook of information for the new board member. Several associations have recently prepared attractive as well as comprehensive manuals of their organizations, and samples of these are available on loan from the N.O.P.H.N. for two weeks to local agencies when they are preparing their own manuals.

Another development of interest to board members is, of course, the National Health Program. Recent publications from the Interdepartmental Committee to Coördinate Health and Welfare Activities that offer interesting study material for boards are:

Toward Better National Health. U. S. Government Printing Office, Washington, D. C., 1938. 30pp.

The Nation's Health. U. S. Government Printing Office, Washington, D. C., 1939, 116pp. 20 cents.

A statement of the place of public health nursing in the Program appears in "The National Health Program and Public Health Nursing" in PUBLIC HEALTH NURSING, March 1939, page 133.

• The sixty-eighth annual meeting of the American Public Health Association will be held in Pittsburgh, Pa., October 17-20, with headquarters at the William Penn Hotel. The chairman of the local committee will be Dr. I. Hope Alexander, director of health of Pittsburgh.

• The fourth World Congress of Workers for the Crippled, under the joint auspices of the International Society for Crippled Children and the English Central Council for the Care of Cripples, will convene at Bedford College, London, England, July 16-22. Those desiring accommodation on the convention ship, the *SS. American Merchant,* may secure space as long as it is available by addressing H. W. Roden, Travel Bureau, Mellon National Bank, Pittsburgh, Pa.

(Continued from page 238)

New York

Poughkeepsie. Vassar College. Institute of Euthenics. June 29-August 9. Conference Group I—Development and Guidance. This group is planned for parents, teachers, social workers, ministers, and administrators.

For further information write to Dr. Ruth Wheeler, Director, Institute of Euthenics.

South Carolina

Columbia. University of South Carolina. June 13-August 4. Courses in Public Health and Sex Hygiene for Teachers.

For further information write to Dr. J. A. Stoddard.

Wisconsin

Milwaukee. Marquette University. June 26-August 4. Courses in Principles of Public Health Nursing, Practice Teaching for Public Health Nurses, Principles and Methods of Teaching, Advanced Nutrition. Field Work in Public Health Nursing and Social Case Work (by coöperating agencies).

For further information write to Sister M. Bernice, Dean of the College of Nursing.

Our Readers Say . . .

THIS COLUMN is intended to serve as a forum for the expression of reader opinion. Only signed letters will be published, although the signature will not be used except with the writer's permission. The National Organization for Public Health Nursing is not responsible for opinions expressed on this page.

FEES FOR ANTEPARTUM VISITS

Does anyone have information in regard to payments for nursing visits to antepartum cases by the patients themselves? In how many visiting nurse organizations are they now asking a regular fee for antepartum visits, and if they are, how often do they get paid? In other words, has progress been made anywhere in the country at large in making the general public appreciate the value of nursing visits to antepartum cases so that the patients are willing to pay? Of course, I know that the insurance companies pay for one visit a month, but I am wondering about it generally.

We have been going along rather haltingly for a number of years theoretically asking for twenty-five cents a visit from the antepartum cases but we do not collect very much, and no one seems to be quite sure what we ought to be doing.

DOROTHY J. CARTER, R.N.
Director, Community Health Association,
Boston, Massachusetts

NEW RURAL DELIVERY SERVICE

We are just in the process of setting up our new maternity program. So far we have had three deliveries—all very successful.

There is no provision for patients who can afford to pay because as an official agency we cannot charge for services. However, we can make enough home visits to teach or supervise the person who will be with the mother during her delivery. Sometimes if we have the doctor's permission, we suggest the value of a graduate nurse to the family or tell them how they can get in touch with one. The state health department suggests that there may be delivery sets made up for rental which will cover the costs of having them made up and the costs of their sterilization. Once I gave directions for making up a pack and had the local hospital autoclave it.

You will be interested in knowing what part the nursing committee has played in setting up the program. They have made up the linen for the deliveries, are gathering more muslin, and are making two layettes for emergencies. The Girl Reserves are making the cotton balls, the gauze sponges, and the cord dressings. The older members have taken the responsibility of explaining the program to the various organizations to which they belong. This last is a very important part of a program in a rural community.

RUTH E. BAKER
County Nurse for Yorktown,
Department of Health,
County of Westchester, New York

ABOUT CAMP NURSING

In planning my school health program for the year I have referred to your manual for guidance. I am hoping that the National Organization for Public Health Nursing will study camp nursing and will have something to guide the nurse who enters this unique field.

Last year was my third year at this camp; my fourth summer in camp. It is entirely different in many ways and intensely interesting. We have boys and girls from a Chicago settlement. To oversee the children we have twelve counselors who are just graduated from college, all interested in social work. So the director nurse and assistant director live quite closely with the other twelve on the staff. It is not only the nursing angle but many times the emotional problems which play a big part in the life of a camp nurse.

MARY M. NEGLEY, R.N.
School Nurse,
Hinsdale, Illinois

HAS COPIES OF MAGAZINE BOUND

I am hoping that I will not miss a copy of the magazine. At the end of each year, I have my copies bound. The material published in the magazine is of great value and I would not be without it.

MARY M. JAMES, R.N.
District Nurse Association,
Toledo, Ohio